



STATE OF ALASKA
HEALTH CARE COMMISSION

All Payer Claims Database Study

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ACRONYMS

ACO	Accountable Care Organization
APCD	All Payer Claims Database
ASHNHA	Alaska State Hospital and Nursing Home Association
ATHS	Alaska Tribal Health System
BRFSS	Behavioral Risk Factor Surveillance System
CMS	Centers for Medicare & Medicaid Services
CPOE	Computerized Physician Order Entry
DHSS	Department of Health and Social Services
DOR	Department of Revenue
DPA	Division of Public Assistance
DSM	Direct Secure Messaging
EIS	Eligibility Information System
ESI	Employer Sponsored Health Insurance
FHC	Freedman HealthCare
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCC	Health Care Commission
HCCI	Health Care Cost Institute
HDD	Hospital Discharge Data
HDHP/HSA	High Deductible Health Plans with Health Savings Accounts
HEDIS	Healthcare Effectiveness Data and Information Set
HIDI	Hospital Industry Data Institute, Inc.
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIX	Health Insurance Exchange
IBIS	Alaska Indicator-Based Information System for Public Health
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NHSIA	National Human Services Interoperability Architecture
PPACA	Patient Protection and Affordable Care Act
SCHIP	State Children's Health Insurance Program
SNAP	Supplemental Nutrition Assistance Program
SOA	State of Alaska
VA	Veterans Affairs

I. EXECUTIVE SUMMARY

The Alaska Health Care Commission (HCC) leads the state's efforts to improve health and health care for all Alaskans and address the rising cost of care. The HCC seeks to develop specific strategies to investigate increased expenditures; service delivery in acute care settings; and driving increased value in health care. Progress on all of these strategies needs careful measurement to show success as well as the need for course corrections. To ensure credibility and accuracy, measurement must be based on objective analysis using data from authoritative, comprehensive sources.

One option for compiling data and producing analysis for this important aspect of health system transformation is an All Payer Claims Database (APCD). In other states, APCD-generated reports inform health care policy efforts, quality improvement initiatives and consumer decisions about high value health care. With this potential in mind, the HCC decided to explore the opportunities and challenges of building an APCD in a unique state with diverse health care needs.

The HCC engaged Freedman HealthCare (FHC) to conduct a study about the feasibility of establishing an APCD. The FHC team reviewed information about Alaska's health care environment, conducted interviews and hosted focus groups. The FHC team used this information to frame options for obtaining broad and deep data resources suitable for measuring progress on health care initiatives. These options were then reviewed in light of "lessons learned" in other states' APCD development efforts.

In focus groups and interviews, stakeholders expressed high interest in access to more robust data about quality and cost of care. Participants wanted assurance that the benefit of any data collection effort would outweigh new costs. The FHC team heard that privacy and security protections should be high priorities in any new data collection system. Participants noted that data collection should be as broad as possible and include payers that do not typically report to APCDs.

Recognizing that a more comprehensive data collection, analytics, and reporting system is an important next step to improving and transforming health care in Alaska, the FHC team identified four options to help Alaska move forward with a more comprehensive data collection model:

- **Repurpose Existing Data** on cost of care, quality, and patient experience reported by the federal government and other organizations;
- **Create a Distributive Model** in which data extracts to support analysis and reporting are created from an annual file submission in a standardized format;
- **Build a Limited Geographic Data Collection Process** that includes data on commercially and self-insured residents and providers in the three largest cities (Anchorage, Fairbanks and Juneau);

- ***Build an All-Payer Claims Database (APCD)*** that collects, manages, and produces reports about the widest possible range of state residents, health care services and cost of care.

The FHC team reviewed each option against a series of evaluation questions and concluded that an APCD offers the most robust, accurate and flexible source of insight into patterns of service utilization, population health, and cost of care. Other options provide limited, narrow views of a particular population or delivery system without achieving the synthesis needed to support complex health care policy decisions. Further, only a statewide, mandatory APCD can reliably gather and analyze data about the greatest number of the state's residents.

Measurement strategy is a fundamental component of the work to guide the health care system in a new direction. In considering how to measure progress, the HCC has taken an important step forward on the road to health system transformation.

II. STUDY APPROACH AND METHODOLOGY

A. Purpose of Study

The Alaska Health Care Commission (HCC) aims to improve health and health care for all Alaskans by containing costs, improving value, and strengthening consumer engagement. The HCC has begun to explore a range of options for gathering the necessary data that will inform strategies to address the state's health care challenges. To understand the options available, the HCC engaged Freedman HealthCare (FHC) to conduct a feasibility study of an All Payer Claims Database (APCD) or comparable data system in Alaska.

The goals of the APCD study are to:

1. Learn more about current data collection efforts in Alaska and where gaps exist
2. Better understand how stakeholders believe utilization and cost data could be used to constrain costs and improve quality in Alaska
3. Understand the barriers to collecting and using these data
4. Learn how other states have used an APCD to achieve similar goals
5. Propose options for managing and sustaining a data collection and analytics capacity such as an APCD.

This final report summarizes findings about the feasibility of building and sustaining an APCD in Alaska, presents additional options to produce actionable data about the cost and quality of care and examines the steps necessary for APCD implementation.

B. Methodology

The project's initial tasks established a foundation for the development of the options later presented to the state. The study methodology included a review of existing documentation from Alaska and national resources; outreach to diverse stakeholders with an interest in measuring health system cost and quality; and an environmental scan of other states' data initiatives. The FHC team presented preliminary findings to the HCC to obtain guidance to shape this final report.

1. Document Review

The FHC team reviewed state, regional, and national documents to understand Alaska's political climate, healthcare champions, technology infrastructure, available cost and quality data, and other relevant information. Table 1 lists the documents reviewed as part of this study.

Table 1: Source Documents Reviewed for Study	
Document	Source
Alaska & United States – State Medicaid Fact Sheets	Kaiser Family Foundation http://www.statehealthfacts.org/mfs.jsp?rgn=3&rgn=1
Alaska DHSS Health Insurance Exchange Planning	Public Consulting Group Reports http://hss.state.ak.us/pdf/AKHealthExchangeReport2012.pdf
Alaska EIS Replacement Project Implementation Advance Planning Document Version 1.2 – January 26, 2012	FirstData for the Alaska Department of Health and Social Services (DHSS) http://notes4.state.ak.us/pn/pubnotic.nsf/0/a55f80742d35585389257aa9007dce51/\$FILE/AK+EIS+Final+IAPD+20120126.pdf
Alaska HRSA State Planning Grant Interim Final Report to the Secretary	Department of Health and Social Services (DHSS) http://dhss.alaska.gov/dph/HealthPlanning/Documents/planninggrant/assets/HRSAreport2006.pdf
Alaska Native Community-Based Focus on Health Disparities Program	U.S. Department of Health and Human Services, the Office of Minority Health http://minorityhealth.hhs.gov/templates/content.aspx?ID=7975
Alaska's Health-Care Bill: \$7.5 Billion and Climbing	Institute of Social and Economic Research at UAA http://www.hss.state.ak.us/healthcommission/meetings/201108/ISER%20Health-care%20Spending%20in%20Alaska%202010%20Report.pdf
Census Report on US Insurance Market	America's Health Insurance Plans (AHIP) http://www.ahip.org/AHIPResearch/
Design Options for a Health Insurance Exchange – Actuarial Analysis	Lewis and Ellis, Inc. http://hss.state.ak.us/pdf/ActuarialReport.pdf
Drivers of Health Care Costs in Alaska and Comparison States	Milliman, Inc. http://www.hss.state.ak.us/healthcommission/focus/healthcarecosts.htm
Facility Payment Rates in Alaska and Comparison States	Milliman, Inc. http://www.hss.state.ak.us/healthcommission/focus/healthcarecosts.htm
HCC Annual Reports (2009-2011)	Health Care Commission http://www.hss.state.ak.us/healthcommission/docs.htm
HCC Commission Meetings	Health Care Commission http://www.hss.state.ak.us/healthcommission/meetings.htm
HCC Membership Roster & Biographies	Health Care Commission http://www.hss.state.ak.us/healthcommission/members.htm
Key Indicators Influencing Alaska's Cost of Care	Alaska State Hospital and Nursing Home Association http://www.hss.state.ak.us/healthcommission/meetings/201110/ASHNHAhospital_dashboard.pdf
Physician Payment Rates in Alaska and Comparison States	Milliman, Inc. http://www.hss.state.ak.us/healthcommission/focus/healthcarecosts.htm
State Medicaid HIT Plan Update (SMHP) version 2.0 – November, 2011	Department of Health and Social Services (DHSS) http://dhss.alaska.gov/HIT/Documents/AK%20SMHP%20v2.0%201232011_No%20Audit.pdf
AeHN Fact Sheet	Alaska eHealth Network http://www.ak-ehealth.org/wp-content/uploads/AeHN%20Fact%20Sheet.pdf

2. Stakeholder Engagement – Focus Groups and Interviews

Stakeholders representing diverse sectors of the Alaska health care community were invited to focus groups and interviews to share their perspectives on health care data and measurement. The list of invited participants (Appendix A) includes representatives from insurance carriers, insurance brokers, state employee and retiree health plans, employers and employer groups, health care providers (hospitals, physicians, and provider organizations), Alaska tribal Health System (ATHS), consumers, public health experts, community planners, and researchers.

The FHC team prepared a briefing paper (Appendix B) that described the purpose of an APCD; other states' APCD reports; and opportunities to use data to advance Alaska's health care cost containment and quality improvement goals. The FHC team sent the briefing paper to stakeholders prior to participant interviews and focus group meetings.

The FHC team developed and used an interview tool (Appendix C) to explore the issues discussed in the briefing paper, including:

- **General:** How much do you know about APCDs? Where do you see Alaska's health care system going?
- **Goals:** What are your primary goals for improving health care cost and quality or transforming the health care system? What changes (if any) do you foresee to achieve these goals? Do you think an APCD could support you or your organization in achieving its goals?
- **Business Use:** What are your most important uses of health care data? What do you wish you could measure? Why can't this be measured now? What reports or information would you like to see out of additional measurement? Who is the audience? Do you think an APCD could help to fill in the gap for additional measures? Do you have ideas or thoughts on possible alternative data sources?
- **Data Atmosphere:** What data do you currently use? Do you have specific likes/dislikes about it? What is your sense of the technical infrastructure in Alaska? How might an APCD affect this?
- **Organizational:** Where should an APCD be "housed"? State agency, shared authority, etc.? Do you have thoughts on sources of support and/or sustainability for an APCD?
- **Concerns/Risks:** What should be considered in designing this? What concerns do you have about implementing an APCD in Alaska? What are the risks to accomplishing the goal of an APCD in a high quality manner, or accomplishing it at all? How should we manage those risks?

The FHC team facilitated three focus groups to brief stakeholders about APCDs, answer questions and collect feedback. Held in Anchorage, each focus group reached approximately 40 stakeholders, including those who joined remotely via webinar. The three focus group sessions invited participants in stakeholder groups as follows:

- **Health Care Purchasers:** insurance carriers, insurance brokers, public purchasers (VA, AK Native Medical Center), SOA Employee/Retiree Health Plan, Employers/Union Trusts.
- **Health Care Planners and Consumers:** Public Health and Policy (Division of Public Health), Community Groups (AK Native Tribal Health Consortium), Community Planners (Denali Commission, Providence Health & Services, AK Mental Health Board), Consumers (individual patients).
- **Health Care Providers:** Hospitals (private and state, hospital association); Individual Physicians; Alaska Tribal Health System; and the VA.

In addition to the focus groups, FHC conducted 17 interviews, each lasting 45-60 minutes. The FHC team asked in-depth questions and heard concerns from individuals. Section V contains a summary of the focus groups and stakeholder interviews.

3. Health Care Commission Response to Preliminary Findings

The FHC team attended the October 2012 HCC meeting to share findings from the focus groups and interviews, and to obtain additional feedback about moving forward with an APCD or similar data system. The presentation helped HCC members understand the process for APCD implementation, operations, analytics, and reporting. The FHC team obtained additional feedback from HCC members to inform this report.

III. HEALTH DATA INITIATIVES AND RESOURCES IN ALASKA

A number of health data system initiatives are currently underway to improve health care delivery and provider payment in Alaska. The systems have varying capacities to produce information about statewide, cross-payer health care system performance. The purpose of this section is to identify whether existing systems or ongoing initiatives could provide detailed or aggregated service and cost data to support the HCC's health care transformation goals.

MMIS and EIS – Alaska's Medicaid Management Information System (MMIS) processes and pays Medicaid claims. The Eligibility Information System (EIS) automates eligibility determination and benefit issuance for the majority of the Division of Public Assistance (DPA) programs. These systems support transactions and payments rather than data analysis. The multi-year process of developing and implementing new systems can culminate in creation of a data warehouse that can serve as a repository for clean data files. Data warehouses are often accessed via business intelligence tools. Over time, these systems could contribute data to an APCD about low-income residents' health care cost and utilization.

Health Information Exchange (HIE) – The primary purpose of Alaska's Health Information Exchange is to manage a secure network that allows providers to share clinical medical record information about their patients. The HIE will provide a record locator service, direct secure messaging, telemedicine services and other communication enhancements to improve patient care. Health data exchange and secure messaging allow doctors and hospitals to replace unsecure fax machines, copiers, and mailing processes with a secure, encrypted method for transmitting health data from point to point, improving efficiency and reducing cost.

Alaska Indicator-Based Information System for Public Health (IBIS): The Informed Alaskans Initiative¹ makes public health data more visually appealing and accessible to the public. The system currently uses data collected via the Behavioral Health Risk Factor Surveillance System (BRFSS), an annual, random sample telephone survey that gathers self-reported information about health status, insurance coverage, access to care, disparities, and disease prevalence. Individuals' personal information is not collected. BRFSS does not collect medical claims or cost of services. The IBIS will expand to include additional public health data, such as vital statistics information, in the future. IBIS is built from a file containing individuals' responses to the BRFSS survey questions. The major components of the system are:

1. **InstantAtlas**, a proprietary mapping tool that uses interactive maps to display public health risk factor surveillance data (BRFSS) spatially and over time; released in June 2012; and

¹ <http://www.hss.state.ak.us/dph/infocenter/ia/default.htm>

2. **Alaska Indicator-Based Information System for Public Health (IBIS, IBIS-PH, AK IBIS)**, a web-based query system. The system provides access to BRFSS data through custom queries.

This data is a valuable asset to the overall picture of health care status.

Hospital Discharge Data – Since 2001, Alaska’s statewide hospital discharge data (HDD) system has collected uniform information on all hospitalizations from participating facilities. The HDD contains demographic characteristics, principal conditions, major medical procedures, discharge status, length of stay, billed charges, and payment sources for hospitalized patients. Alaska stakeholders agreed to voluntary participation in the HDD rather than statutory mandate. Eleven of Alaska’s twenty-seven hospital facilities currently submit data, with participating hospitals in the State representing approximately 75 percent of discharges statewide. Alaska’s two military hospitals, two mental health hospitals, six regional Tribal Health System hospitals, and one long-term acute care hospital do not submit data. As in other states, reports from Alaska HDD data track acute care utilization, cost, and quality of care.

IV. ALL PAYER CLAIMS DATABASES

APCDs are powerful tools that can address the need for comprehensive information about health and healthcare across all settings of care. States' motivation for collecting these data include informing efforts around cost containment and quality improvement, supporting payment reform activities, assessing access or barriers to care, studying utilization patterns, and informing policy decisions. The purpose of this section is to describe existing APCDs and to identify opportunities relevant to Alaska's health care system goals.

Every health encounter creates a claim for payment. Public and private insurance plans routinely aggregate these claims data into administrative databases. APCDs combine data from a state's payers, including Medicare, Medicaid, private insurers, state employee benefit programs, and self-insured employer plans. The databases generally include data on eligibility; medical, pharmacy, and dental claims; and provider information.

APCDs support modeling, analysis, and reports across the health care system. For example, comprehensive information about disease incidence, treatment costs, and health outcomes is essential for informing and evaluating state health policies. These data are the foundation for decision support tools that help consumers make informed choices based on quality and cost. Policy makers and health plans can use these data to model changes in payment policies, assess the effects of changes in health care policy and delivery, and monitor cost trends.

APCDs may be governed in a variety of ways, ranging from entirely public entities (housed in a state agency), a private entity (such as a non-state non-profit organization), or a hybrid model combining the two. Data submission can occur either as a statutory/regulatory mandate (requiring all health plans to contribute data by law), or voluntary efforts.

A. Creating a State Mandated APCD

Most states opt for a mandatory APCD governed by statute and rule making authority. This public process helps establish a framework for building trust and for ongoing conversations about data use. Moreover, legislative direction allows health plans to disclose protected health information under the public health authority exemption of the Health Insurance Portability and Accountability Act (HIPAA). Legislation may also require the state Medicaid program and self-insured state employee programs to submit data. State regulations set out specific information about submission requirements, timelines, and penalties. Statute and regulation also define acceptable uses of the data and a process for reviewing data use applications.

In other states, the time elapsed between starting an APCD effort and obtaining the first report based on its data is usually 24 to 30 months. The timeline includes legislative action, state regulatory action, hiring a data manager, collecting the first round of data and then producing reports and analysis. "Lessons learned" from successful APCD states may result in a shorter timeline for future APCDs, perhaps reaching the reporting milestone at approximately 20

months. Table 2 describes the steps other states have taken to implement their APCDs with an overall timeframe ranging from 19 months to 30 months.

Table 2: Typical APCD Timeline		
Activity	Purpose	Estimated Duration
Legislation	Obtain legal authority to collect data	At least 4 months
Reporting Plan	Formal, high level description of how the data will be used and governed	1-2 months
Rules and Data Submission Guide	Work collaboratively with data submitters on data specifications and rules	At least 3-4 months
Data Manager under contract	Obtain contracted expertise	3-6 months
Data submission starts	Test data first, then a 3 year history file	Begins 5-7 months after data submission guide is issued
Reports produced		3-6 months after history data due date

Table 3 displays the variation in the structure, authority, and breadth of nine APCDs that are now collecting data.

TABLE 3: Variation in APCD Structure									
	CO	MA	ME	MD	MN	NH	OR	TN	VT
Governance Model	Private Non-Profit	Public State Agency	Public State Agency	Public State Agency	Public State Agency	Public State Agency	Public State Agency	Public State Agency	Public State Agency
Legislative Authority	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission	Existing; Mandatory Submission
Medicaid	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Medicare	Planned	Yes	Yes	Yes	Yes	Planned ²	Yes	Planned	Planned
Commercial Health plans	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Third Party Administrator/ Self-Funded	No	Yes	Yes	Yes ³	Yes	Yes	Yes	Yes	Yes
Uninsured	No	No	Some ⁴	No	No	No	No	No	No
First Year of APCD Collected Data	2009	2008	2003	1998	2008	2005	2011	2009	2007
Data Release Policy	Yes	Yes	Yes	No	No	Yes	No	No	Yes

² Although Medicare data is currently collected, it is not integrated with the commercial data (separate release policies). Application for Medicare data is currently underway

³ Does not include stand-alone Third Party Administrator payers or self-pay

⁴ Pseudo-claims for some uninsured

B. How States Use APCDs

A growing number of states are utilizing or developing APCDs. This section highlights how APCD data supports a range of policy, planning, and research projects.

- **Public Reporting on Price and Quality** –Public or private entities can use APCD data to increase transparency in cost and quality data. Two states that have used an APCD in this way are Massachusetts and New Hampshire.
 - Massachusetts’ “[My Health Care Options](#)” website displays cost and related quality measures for a limited set of hospital-based procedures. Consumers are able to search by provider name, condition, or procedure, or by a radius around a particular zip code. This website provides explanation and detail at three levels: summary ratings with one to three dollar signs and stars; a second screen with detail about the quality rating; and a third level showing the cost measures and comparisons to statewide benchmarks.
 - [New Hampshire Health Cost](#) uses data derived from APCD submissions to generate an estimated cost of a procedure by facility. In combination with additional information provided by insurers, the tool uses the consumer’s deductibles and co-pays to show the consumer’s estimated total cost, as well the precision of the estimate.
 - Colorado intends to use its newly launched APCD for publicly reporting regional and statewide variations in cost (www.cohealthdata.org). Future updates include procedure specific cost comparisons to support consumers seeking high quality care at the best price.
- **Clinical Performance Improvement** – Large claims databases offer important opportunities to identify high performing clinical groups and learn how high quality, effective clinical systems deliver care. APCDs seek to build a longitudinal portrait of each individual’s claims. This data provides a strong foundation for standardized metrics that help clinicians identify promising practices for improving care. In Minnesota (and in development in Colorado), APCD data is used to provide cross-payer quality reports that allow providers to look at performance across the entire practice, eliminating the need to read and interpret reports from all health plans.

Voluntary data collection organizations -the Wisconsin Health Information Organization and the Puget Sound Health Alliance in Washington State- offer provider specific, cross-health plan quality data. In Rhode Island, the Rhode Island Quality Institute is collecting utilization data from health plans to evaluate the effect of the federally funded Beacon Community Program on provider practices, with particular emphasis on the effect of electronic medical records and other practice-level technology investments.

Looking ahead, the “next generation” in Colorado, Connecticut, and New York is building a system to align claims-based quality information with outcome results drawn from health information exchanges. To accomplish this ambitious vision, designers are

building processes that uniquely identify each individual in the APCD so that other data sets can use the same processes to facilitate matching. Analysis drawn from both data sources supports clinical effectiveness research to identify best practices.

- **Information on Quality and Cost Trends for Public Policy Decision Makers** – A number of states have used data from an APCD to provide additional analyses on quality and cost trends to inform public policy decision makers.
 - Maine has used its database extensively to document the cost of certain adverse health events and evaluate the effectiveness of a medical homes pilot.
 - New Hampshire constructed a comprehensive health care information system that allows a user to analyze any number of health system questions.
 - Vermont has used its APCD for an expenditure analysis by type of service and studied provider reimbursement for primary care services.
 - Massachusetts has conducted annual cost trend analyses on its health care system using a large multi-insurer claims database, transitioning to APCD data in 2011.
 - Minnesota is creating provider peer comparison reports to provide consumers, health plans, and providers with best practices and greater transparency about value in health care. The reports allow comparison of health care providers based on a combination of risk-adjusted cost and quality, for a provider's total patient population as well as for select specific health conditions.
 - Colorado recently began reporting on total cost of care for commercially insured and Medicaid covered individuals.
 - **Implementing the Affordable Care Act and Supporting States' Health Care Reform Efforts** – Several state are exploring how they can use their APCDs to fulfill reporting and other requirements under PPACA. For example, Massachusetts is using its APCD to support an alternative risk adjustment methodology under the PPACA Premium Stabilization Program. Moreover, Massachusetts is emphasizing administrative simplification and consolidation of regulatory reporting requirements in an effort to control the growth in non-medical insurance company costs. Massachusetts also uses the APCD to develop analytic reports for the annual health care cost containment hearings conducted jointly by the state Attorney General and the Center for Health Information and Analysis.
- APCD states are considering using their APCDs to develop required quality reports about readmissions and hospital acquired infections for members enrolled in health plans in and out of the Exchange.
- **Studying Geographic Variation** – Public program administrators use APCDS to understand patterns of utilization and the value of care delivered to a given population in a geographic region. A well-known example is the [*Dartmouth Atlas of Health Care*](#)

that analyzed Medicare data to show variations in the way elderly Americans use health care resources. A 2009 analysis⁵ used APCD data to show that differences in spending do not predict differences in health outcomes. While patients in high spending regions may receive more health care, several studies have found that those regions do not necessarily achieve better outcomes. An APCD that includes Medicare, Medicaid, and private health plan data will extend the Dartmouth lens and help examine the total cost of care for similar patients regardless of health plan and reimbursement methodology. Such data eliminates “quality silos” of past studies and supports a more robust conversation about care delivery.

- **Population Health Analysis for Public Health Officials** – APCDs could dramatically alter the analyses conducted by public health programs to develop, evaluate, and report on the impact they have on their targeted, and oftentimes underserved, communities. APCD data supports reporting about surveillance and monitoring gaps. APCD data estimate the prevalence, assess standards of care, examine the financial impact, and evaluate program impact of a particular disease or condition.

Other reporting examples include:

- Supplementing existing surveillance reports that focus on outcomes with expanded measures of morbidity using claims, pharmacy, and product file data;
- Assessing patterns in overuse of various medical services including imaging; and
- Understanding the costs of managing chronic illnesses across all health care settings.

C. How States without Mandated APCDs Obtain Data

States that do not have an APCD use various methods to obtain the necessary data in order to meet their reporting goals. Data calls or distributive data models, discussed later in this report, can be issued by a state regulatory agency on a periodic basis to meet specific reporting needs.

Before establishing its APCD, for example, Massachusetts used periodic data calls to the large health plans in the State to study system health care cost drivers. These data calls meet a specific research or analysis requirement to minimize the amount of data provided by health plans. States can sign agreements with health plans describing the agreed upon uses of the data, or assign a third party (such as a university research unit or nonprofit organization) to collect and store the data. Such an arrangement could also expedite report production by eliminating a data transfer from one organization to another. Note that the quality and standardization of voluntary submissions are difficult to monitor because the data submitters are not obligated to correct problems with the data.

⁵ Gawande, Atul, “The Cost Conundrum,” The New Yorker, June 1, 2009 accessed at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

Other states interested in greater price transparency passed laws requiring the prices for common procedures by providers be available to the public. Minnesota and South Dakota maintain websites in this regard⁶; see Appendix F for information about these models. A number of states have web-based provider and hospital price disclosure plans as well, with efforts ranging from statewide initiatives in California, Florida and Maryland, to single hospital system efforts such as Catholic Health Initiatives in Denver, Colorado. In addition, several hospital associations in Iowa, Louisiana, Michigan and Wisconsin have voluntary efforts, and a number of private insurance companies are working on cost reporting (United Healthcare, Aetna, Humana, and WellPoint). These efforts are evolving in response to consumers' evolving awareness of health care costs.

Nonprofit organizations such as the Hospital Industry Data Institute collect and analyze provider data, producing reports for internal quality improvement efforts.⁷ Foundation grants and membership fees fund these organizations' reporting activities.

Business groups have also established reporting initiatives, including national efforts by the Leapfrog Group and Bridges to Excellence as well as regional efforts such as the Pacific Business Group on Health. Leveraging the strength of having providers and health plans on their boards, business groups create a demand for a better health care system and put pressure on the provider community to play a role in the effort. Building on this foundation, health plans pair quality data with cost and/or efficiency measures to build high performance networks. Though progress may seem slow, these organizations work carefully and deliberately to establish trust with stakeholders.

The Health Care Cost Institute (HCCI) is a non-profit, nonpartisan organization that seeks to provide information about the cost of care provided to individuals with employer-sponsored insurance, the source of most coverage for full time workers. Four commercial health insurers -- United, Aetna, Humana, and Kaiser Permanente-- are jointly funding this initiative. These health plans voluntarily provide annual de-identified claims data files. To date, HCCI has published national trend reports for calendar years 2009 through 2011. HCCI also releases data to academic researchers studying topics such as the effects of aging on health care costs; the effect of economic downturns on health insurance risk pools; and the determinants of and variation in hospital pricing. The database currently holds 50 million covered lives, with Alaska residents representing 60,000 of that total. Looking ahead, HCCI welcomes discussions with states seeking to build statewide health care cost and utilization databases. HCCI could provide an extract of data about Alaska's residents and merge it with voluntary data submissions from in-state health plans that do not participate in HCCI. In addition, HCCI could provide data warehousing and analytic services.

⁶ National Conference of State Legislators. <http://www.ncsl.org/issues-research/health/transparency-and-disclosure-health-costs.aspx>

⁷ Alaska Hospital Association partners with HIDI (Hospital Industry Data Institute) for their HDD. HIDI is a nonprofit and works with AK, Georgia, Kansas, Missouri, TN, Virginia, WA, Wyoming. <https://www.hidionline.com/HIDI/Partners.aspx>

Summary

APCDs encounter fewer obstacles with clear statutory authority to require data submissions from all health care health plans in the state. When the APCD is underway, the types and variety of reports produced can address a wide range of questions about health care system performance consistent with the HCC's health system transformation goals.

V. FINDINGS FROM STAKEHOLDERS ABOUT AN APCD

To obtain stakeholders' perspectives regarding the concerns and opportunities for enhanced data collection and analytic capacity, the FHC team conducted focus groups and extensive interviews described earlier in this report. This section is a summary of key outcomes derived from the stakeholder process. Please note that the FHC team promised anonymity to participants; therefore, individuals and specific organizations are not named in this section.

A. The Emerging View on APCD and Uses for Data

Overall, the FHC team heard great enthusiasm for enhanced and expanded health care cost and utilization data resources from government agency staff and the health policy community. Participants recognized that escalating costs of care, especially for Alaska Medicaid recipients, combined with growing concern about quality and access for all state residents, are serious and persistent issues. Participants recognized the value of an APCD and standardized benchmarks, as well as the opportunity to create models, trending studies and meaningful reports. Members of the HCC were particularly knowledgeable and supportive of a statewide database.

Feedback from providers and insurers indicated a desire for more widespread stakeholder input before the HCC moves forward with an APCD. Some participants thought that the Legislature would be reluctant to act on any issue related to data privacy. Payers were uncertain about how an APCD's reporting capabilities would add value to their specific business models, especially given that major commercial payers use internal data systems to monitor their enrollees' health care services cost and utilization. ATHS, VA, and TRICARE representatives were also uncertain about how an APCD could provide useful information for their organizations.

While most stakeholders recognized that data from an APCD would be valuable for population health monitoring, participants held much more diverse opinions about how to use APCD cost information. Some speculated that greater transparency about the cost of specific services would simply lift the average price and drive costs up. Given the lack of provider choice in Alaska, participants wondered how price transparency would truly affect change. Ultimately, few participants recognized an immediate or urgent role for the APCD in supporting payment reform and transparency efforts.

What Alaska State Agencies Want to Measure

State agency staff would welcome more robust data to measure and monitor health system activity. For example, participants would value reports about emergency department utilization "before" and "after" a new policy or initiative begins. Participants seek data to identify best practices and set performance standards. State representatives also expressed interest in using APCD data for analysis that quantifies cross-payer cost shifting and models the effects of different purchasing strategies on the health care system.

State staff reported that the Medicaid program is currently updating its old COBOL-based MMIS system, which had significant limitations for data analysis. Staff anticipates that the new MMIS

system ultimately will support development of reports and analysis that examine past use of services and inform design of new payment methodologies such as bundled payments and pay-for-performance.

Participants noted that approximately 30 percent of Alaska's Medicaid beneficiaries also have access to the Alaska Tribal Health System. APCD data could provide historical diagnostic and service utilization information that could improve care delivery. This information also supports resource allocation studies, clinical effectiveness reviews, and comparisons across systems of care.

Participants recognized that the APCD could provide benchmarking data for public and private payers. The state government oversees health benefits for over 180,000 individuals, of whom 44,000 are employees and retirees. DHSS would like to compare quality, utilization, and cost measures for commercial and other public populations.

What Alaska's Health Care Providers Want to Measure

Providers in general were relatively uninformed about the business case for additional data reporting through an APCD or similar system. The FHC team heard that, compared to other states, Alaska's provider community is less engaged in transparency and quality improvement. Participants identified a need for provider education and incentives if a measurement initiative grew out of APCD reporting efforts. Participants expressed an interest in secondary uses of the data for tracking patients across the health care system, comparing patterns of care and utilization across payers, and developing provider-level quality measurement. In addition, some providers hoped the data would inform their strategies and understanding of health care utilization, quality, and cost. Providers were concerned about resources needed to analyze and interpret the data in meaningful ways.

How Employers Want to Use Health Care Data

The HCC recognizes the important role employers can play in establishing and using a new data collection and reporting system in Alaska, and were disappointed employers were not part of the stakeholder groups interviewed for this project. Employers in other states support data collection efforts to encourage employees to obtain treatment from high quality, cost effective providers. For example, employers are increasingly seeking health plans that have demonstrated high-value networks that are effectively containing cost increases.

Employers in states with a high penetration of managed care plans have used cost and utilization data to determine whether selected health plans (commercial and self-insured) are promoting individual responsibility for accessing and using prevention and wellness services and/or appropriately using the emergency department.

How Consumers in Alaska Can Use Health Care Data

Consumers play a critical role in driving the transformation of care delivery. Among those who participated in the focus groups, consumers clearly indicated a desire for greater transparency of health care data, particularly as it relates to out-of-pocket costs for treatment.

Consumer interest in high quality, high value care is accelerating nationally as employers turn to High Deductible Health Plans with Health Savings Accounts (HDHP/HSA). These plans require consumers to pay directly for services up to a certain amount, offset by pre-tax contributions to a health savings account, sometimes with contributions from the employer. As shown in Table 4, the number of commercially insured Alaska individuals in HDHP/HSA plans tripled between 2010 and 2011.⁸

TABLE 4: Alaskans in High Deductible Health Plans and Health Savings Accounts		
Year	Alaskan's in HDHP/HAS Plans	Percentage of Population
2010	10,206	2.4%
2011	33,709	8.7%

According to health care economists, consumers will become managers of their own healthcare when they have useful, accessible information about treatment choices based on quality and cost.⁹

B. Stakeholders' Views about an APCD

Participants emphasized the need for 100 percent participation from all payers in order for an APCD dataset to be meaningful. Payers recommended legislative action requiring data submissions from all health plans including self-insured employers. Participants recognized that some organizations and entities would be reluctant to participate and noted that public payers must also contribute to complete the picture. National health plans hoped that Alaska would benefit from the experiences of other states and adopt national standards, such as the X-12 claims transaction.

A number of stakeholders mentioned the limitations of an APCD, such as the lack of data on the uninsured. In addition, providers were concerned about data missing from non-claims related transactions between provider and insurer due to self-payment by the patient and/or claims denied by the insurer. Stakeholders wanted more information about the potentially complementary roles of the APCD and HIE, emphasizing that the two should ultimately be combined – built together and/or integrated.

Hospital representatives felt that published data from an APCD should focus on valid measurement methodologies and national benchmarks, and should provide a context for the reporting. The provider community agreed that published APCD data and analysis should be based on nationally accepted analytic methods and tools and accompanied by clear explanations about the limits of claims data.

8 America's Health Insurance Plans, "January 2012 Census Shows 13.5 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)", <http://www.ahip.org/HSA2012/>; "January 2011 Census Shows 11.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs);" <http://www.ahip.org/HSA2011/>; "January 2010 Census Shows 10 Million People Covered By HSA Qualified High-Deductible Health Plans; <http://www.ahip.org/HSA2010/>

9 Improving Quality Health Care: The Role of Consumer Engagement. <http://www.academyhealth.org/files/issues/ConsumerEngagement.pdf>

A number of stakeholders were eager to learn more about how APCD states were gaining traction with their reporting efforts and to learn more about how states have used the outputs to monitor progress on state health policy and reform initiatives.

Most stakeholders mentioned that Alaska has little experience with quality measurement. Although mandatory federal reporting has spurred transparency efforts, quality measurement has not yet been widely embraced by Alaska's physician community. While some providers were supportive of movement in this area, others were wary of how quality would be measured.

C. Governance and Privacy

With respect to oversight and decision making about data use policy, some participants felt that a single point of contact within state government should oversee the APCD. Most participants believed the process for developing regulations should be collaborative to build trust among all parties. Some saw a need to educate the provider community about how the data will be used. For example, Colorado, Connecticut, and Rhode Island have actively engaged stakeholders at all points in the development process. In particular, national health plans would welcome a similar process in an Alaska APCD development process, including framing regulations, designing the data intake specifications and building the data release process.

One health plan felt a distributive model reliant on annual voluntary data submissions might work better in Alaska instead of a traditional APCD. In addition, privacy is a big concern in Alaska, expressed by nearly every stakeholder interviewed. Stakeholders agreed that Alaskans see operating a centralized database as carrying some degree of risk. Alaska has only a few population centers, while the remaining population resides in very small, rural communities, making privacy a more serious concern than in other states.

D. Resources and Timing

Participants were eager to learn the cost of establishing and maintaining an APCD in Alaska, especially over the long term after the initial start up phase. Some participants felt that Alaska's state government could support a new health data collection system. Participants recommended conducting a cost benefit analysis to demonstrate the value of the initiative.

Participants were concerned about capacity within state government to work with and analyze claims data. Significant resources would be required to hire and train suitable staff or to contract out for such expertise. Participants noted that Medicaid's new MMIS system design process is an opportunity to leverage data management and analytic capacity.

Several stakeholders wanted to learn more about timing of such an initiative both in terms of establishing a database from start to finish and the time lag between receipt of data and production of data files for analysis.

VI. OPTIONS FOR DATA

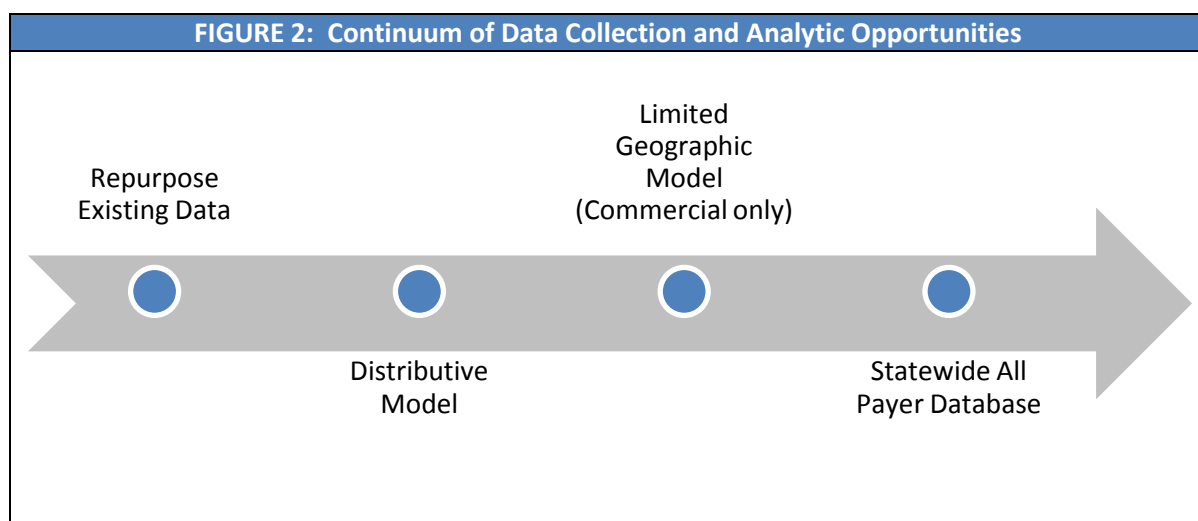
A. Data vs. Information

The study yielded a wealth of information about the Alaska health system and the ways in which additional data resources could support the HCC's transformation goals. With high interest in ensuring that health care costs do not escalate out of control, the Alaska health care community seeks to take informed action when transforming the health care system.

Cost and utilization information are essential tools in understanding what happens where and when, modeling the options and measuring the outcomes. Alaska's stakeholders must be confident that the current state of affairs is well documented and that different paths to a future state can be modeled and reviewed for course correction using both quantitative and qualitative information.

The options presented in this section illustrate a continuum of complexity, cost, and investment, as seen in Figure 2. Selecting an option on the less complex portion of the continuum may be a starting place on a roadmap to more robust and granular data if the HCC recommends that choice for the State. This section describes four options according to the following characteristics:

1. **Source or sources of the data:** What entity owns the data and how is it obtained?
2. **Measurement targets:** To what extent can the available data sources measure the cost of care, patient experience and population health for all residents at a meaningful level of detail?
3. **Resource investment:** What skill sets will be needed to produce the necessary reports? What is the approximate cost of establishing and maintaining the data?
4. **Implementation Timeline:** How much time is needed to produce reports and data?



B. Option 1: Repurpose Existing Data

1. **Description and Examples:** The State of Alaska, the federal government and other national organizations collect information about the cost of care, quality, and patient experience. In this model, the product would be a consolidated report that gathers previously published information into a unified format.
 - a) The Commonwealth Fund publishes the Local Community HealthCare Score Card using data from CMS, the US Department of Health and Human Services, the US Census and a commercial data source, Marketscan.
<http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx>
 - b) The California Health Foundation publishes HealthFacts 101 based on data from CMS and other federal agencies.
 - c) <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareCosts12.pdf>
 - d) Massachusetts “Key Indicators” is an example of a report developed with these types of information. It provides an overview of the health care landscape based on data reported by providers, health plans, government, and surveys of Massachusetts residents and employers.
<http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/11/2011-key-indicators-may.pdf>
2. **Sources of the Data:**
 - a) CMS Hospital Compare: Safety and complications
 - b) HCAHPS: Patient satisfaction and experience of care
 - c) US Census: American Community Survey: population health
 - d) National Expenditure Survey: Summary per capita cost information
 - e) <http://www.cms.gov/NationalHealthExpendData/>
 - f) Kaiser State Health Facts: Population health status
 - g) Medicaid Statistical Information System (MSIS) Data: CMS aggregated Medicaid data by state <http://www.cms.gov/MedicareMedicaidStatSupp/>
 - h) Vital Statistics, Behavioral Risk Factor Surveillance System
 - i) IBIS, the Alaska Indicator-Based Information System for Public Health
 - j) Alaska Hospital Discharge Data, as available

The sample size (number of records in a data set) presents particular challenges for using national data sources to inform Alaska health policy. For example, as of November

2012, the Leapfrog Group¹⁰ reports on only two hospitals in the state. NCQA Health Plan Ratings examine health plan performance on access and service, qualified providers, staying healthy, recovering from illness, and managing chronic illness. Currently, only two plans operating in Alaska have applied for accreditation.

3. **Measurement Topics:** Each of the data sets offers a separate lens on health system performance; none captures information for all Alaska residents. Most report information for the State as a whole rather than particular geographic areas or counties/boroughs. Hospital Compare examines patient safety data on Medicare patients. HCAHPS examines patient experience measured by surveys given to hospital patients. NCQA measures are available only if the plan has applied for accreditation. Population health data is available at an aggregated level; Behavioral Risk Factor Surveillance System (BRFSS) sample sizes can preclude analysis with more detailed levels of geographic and other demographic information.
4. **Resource investment:**
 - a) **Data acquisition:** Efforts to acquire the data are minimal; these datasets are sufficiently small such that typically available internet resources are sufficient. Many of the datasets are available on the data owner's website; private organizations may require a formal agreement before the measurements can be re-used on a state's website.
 - b) **Analysis:** To set expectations and ensure continuity, a comprehensive specification document spells out the selected reports and metrics. Using this document, an analyst with experience in applying simple statistical tests could produce annual or twice yearly updates. Report writing and editing support are helpful project additions for explainers and "takeaways." Assistance with graphical presentation is also helpful in creating a unified product.
 - c) **Cost:** The cost of this option for data storage and manipulation is the lowest cost option of the four discussed in this section. The major expense derives from developing the instructions for the analytic methodology, conducting the analysis and creating explanations and presentations of the results.

¹⁰ As of November 16, 2012, the Leapfrog Group Website returned the names of two hospitals. This website is updated periodically and may return different results on a later date.

http://www.leapfroggroup.org/cp?frmbmd=cp_listings&find_by=state&city=&state=AK&cols=a.b.c.d.e.k.f.g.h.i.j.oa

Estimated Cost Table 1: Repurposing Existing Data			
Task	One Time Start Up Cost	Ongoing Annual Cost	Assumptions
Data collection	\$50,000	\$10,000-25,000	Leapfrog data requires a license
Analytic and Policy Studies	\$100,000 for design, specifications and testing	\$50,000-\$150,000	Dependent on number, frequency and complexity of reports Includes graphic and presentation services
System Maintenance	None, other than standard backup/file recovery processes	None, other than standard backup/file recovery processes	All datasets are small enough to store within typical spreadsheet software
Overhead and Process Management	May require short term staff support	Could be addressed with existing staff	Resource at the state to manage process and provide oversight of technical issues and project management
TOTALS	\$150,000+	\$60,000-\$175,000	

5. Timing:

- a) Obtaining the data: These data sets are relatively easy to obtain since they do not contain protected health information and are relatively small. The data can be downloaded and imported into widely available spreadsheet applications. Updates are available at different times per year or at multi-year intervals.
- b) Analyzing the data: At the outset, the State or its designee will need approximately two to three months to develop a methodology and format. This estimate includes discussions with stakeholders and training an analyst. Once the process is standardized, the updates could be available within a week of a data update.
- c) Producing a report: The initial effort to provide written and graphical representations usually requires at least two iterations; exact duration depends upon the number of reviewers participating in the process. Once the process is underway, production times will decrease.
- d) Total estimated time: Three to four months to produce the first report. Later updates depend upon the frequency of refreshed data.

Summary Table 1: Repurposing Existing Data	
Strengths	Limitations
<ul style="list-style-type: none"> • Provides some information about population health and patient experience • Less complex data collection process • “Repackages” and collects previously released information • Builds capacity to analyze data and present results • Does not require significant ongoing resource investment 	<ul style="list-style-type: none"> • Available data sources do not measure all of the same populations (e.g. Hospital Compare looks at Medicare only) • Little or no ability to drill down on population health, cost or patient experience • Accurate examination of trends depends on the data source maintaining consistent methodologies • Little or no data on the uninsured

C. Option 2: Distributive Model

1. **Description and Examples:** A distributive data model that addresses the need for state-specific information at regular intervals allows more granular and flexible analysis than Option 1 “Repurposing Existing Data.” A distributive model could be based on voluntary data submissions or required by statute and legislation. In this model, health plans usually submit annual files, eliminating the monthly data updates that drive complexity and cost in a full APCD. Some data cleaning and checking would be required, and data extracts would be prepared to support analysis.

A distributive model could begin with three years of claims and member data from Premiera, Aetna, United, and any other self-insured entities. When the new MMIS is fully implemented, Medicaid data could be added. Alaska could also request Medicare files from CMS. This model is similar to the Maryland APCD that obtains annual aggregate data to populate a statewide report. See the “Maryland State Health Expenditures Report for 2010, released May 23, 2012.”¹¹

In a voluntary arrangement, health plans would provide de-identified data to avoid concerns about authority for data disclosure. A required data submission would direct health plans to provide data that could be used to create a longitudinal portrait of an individual’s care over time and across settings.

2. **Source or sources of the data:** Commercial health plans could directly supply data for fully insured and self-insured individuals according to a standard format provided by the State. An alternative source for Aetna and United Healthcare data is the HCCI database, which is available at a fee for research purposes. Alaska’s new Medicaid Data Warehouse could contribute an annual Medicaid dataset when fully implemented. The state will also be able to obtain Medicare data extracts under the CMS State Agency

¹¹ State Health Care Expenditures. http://mhcc.dhmf.maryland.gov/healthinmaryland/Documents/2012-04_shea_051512.pdf

request process. To obtain federal data from TRICARE, Indian Health Services, and Veteran Affairs, the APCD and the responsible federal agencies would enter into a negotiation about data use.

3. **Measurement Topics:** Once the data from all sources is collected, an annual portrait of Alaska's health care system can be assembled. With standardized data sources and analytic techniques, this model supports a robust analysis of trends in total medical cost and for specific services and provider types, as well as utilization of certain services. These data can also support insurer-specific analysis of illness burden, resource consumption and opportunities to explore best practices in health care delivery such as emergency department visits. In addition to supporting inputs to alternative payment models, other reporting options include average private prices for top 25 procedures and rate of ambulatory care sensitive emergency department visits. For population health purposes, this model can measure access to care, incidence of chronic conditions, level of insurance coverage or geographic proximity to primary, specialty or emergency care.

Note that a distributed model does not support analysis of patient experience of care. In addition, the ability to follow a patient's course of treatment is limited to enrollment in a particular health plan. This will obscure longitudinal analysis of care, especially when individuals obtain, lose and re-access insurance coverage.

4. **Resource investment:**
 - a) Obtaining data: Steps to acquiring this data include creating and executing the agreements to acquire the data; building a central repository; and managing the actual data transfer process. Fees for Medicare data and a HCCI data extract estimated upon request. Staff support to work with federal agencies would be required.
 - b) Storing data: Alaska's Medicaid Data Warehouse may have capacity to accommodate this data. Analytic tools would be needed to develop the measurements for annual reporting. In the interim, an outside entity could be developing the analytics and report methodology in anticipation of the Data Warehouse's availability.
 - c) Analyzing data: Once the analytic infrastructure and process is established, running the reports, producing write-ups and creating the public presentation would require analytic, writing and graphics design support.

Estimated Resource Cost: For comparison, the full cost of the Maryland APCD costs approximately \$1 million per year, as shown in Estimated Cost Table 2. While Maryland's population is eight times that of Alaska, system costs do not scale accordingly. Note also that the Alaska cost of analytic and policy studies may be higher without current internal staff capacity.

Estimated Cost Table 2: Distributive Model				
Task	One Time Start Up Cost	Ongoing Annual Cost	Maryland Annual Ongoing Estimate	Assumptions
Data Collection	\$50,000-\$75,000	\$50,000 to \$175,000,	\$400,000 (35 commercial carriers)	Cost of managing intake for four commercial carriers providing data files directly to state; could increase when other agencies begin to provide data; cost covers creation of data specification; secure file transfer and assistance to health plans
	\$30,000 - \$50,000	\$30,000-\$50,000		Medicare data fees
	\$50,000 - \$100,000	\$50,000 - \$100,000		Medicaid data extract cost (based on other small state)
Analytic and Policy Studies	\$50,000-\$150,000	\$50,000-\$100,000	\$250,000	Startup costs reflect report design process; annual cost is production and quality assurance. Dependent on number, frequency and complexity of reports
System Maintenance	\$20,000-\$100,000	\$20,000 - \$150,000	\$250,000	Very low end assumes leveraging Medicaid data warehouse capacity at minimal cost; upper end is contracted entity.
Overhead and Process Management	\$25,000-\$50,000	\$25,000 - \$100,000	\$100,000	Resource at the state to manage the data acquisition process and provide oversight of technical issues and project management
TOTALS	\$175,000-\$525,000	\$175,000-\$600,000	\$1,000,000	

5. Timing:

- a) Obtaining the data: This option assumes that health plans will voluntarily provide this data; no legislative action will be needed. Given the number of data sources and different acquisition strategies, obtaining all the files as follows:
 - i. Commercial data directly from health plans: 3-6 months after the end of the designated period. With respect to HCCI, participating health plans supply data annually, six months after the end of the calendar year. (Note that Premera does not currently participate in HCCI.)
 - ii. Medicare State Agency Request: 3-6 months to receive data after request for a period ending approximately six months before the data are delivered.

- iii. Medicaid Data Extract: Available when the Medicaid Data Warehouse is fully implemented.
- b) Analyzing the data: Data cleaning and analysis usually requires approximately three months. Benchmarking and report production would follow. Additional time should be included for pre-release review with stakeholders to explain methodologies and interpret results.

Total Estimated Time from Initial Data Collection to first reports: Approximately 12 months for commercial and Medicare data; Medicaid and other federal payers likely require a longer timeline.

Summary Table 2: Distributive Model	
Strength	Limitations
<ul style="list-style-type: none"> • Data are available for approximately 95% of the commercially insured private market assuming participation by all commercial carriers • No statutory or regulatory authorization needed for voluntary submissions • Small number of large health plans • Data would support payment reform analysis • Enables project to gradually garner support for expanded data collection • De-identified data inputs mitigate health plans' concerns about disclosing private health information 	<ul style="list-style-type: none"> • Voluntary data submissions do not ensure compliance with data specification • Self-insured data may not be provided • Cannot follow patients across health plans • Without audit capacity, measurement accuracy may be challenged by providers • Reports would only be available annually • Uses of the data will be limited by the terms and conditions of the Business Associate Agreement (Health plans may refuse to let the state perform certain studies) • No uninsured data is available

D. Option 3: Limited Geographic Model (Commercial Only)

1. **Description:** Conversations with stakeholders indicated that health care resources for commercially insured individuals are concentrated in the more urban areas of the State (Anchorage, Mat-Su, Fairbanks, Juneau, and the Kenai Peninsula). Data about providers located in more sparsely populated areas may not meet minimum standards for public reporting based on a threshold number of observations. In recognition of this geographic distribution, the state could limit data collection and reporting to its most populous areas, where consumers have a choice of providers.

A Limited Geographic APCD might require partial or complete datasets from the federal agencies that provide health care in Alaska. The APCD could request Medicare data through the CMS State Agency Request initiative that permits use in state-sponsored APCDs.

2. **Potential Data Sources:** With the focus of this model on commercial claims data, health plans could supply this information on a periodic basis. Health plans typically provide voluntary submissions once a year, approximately six months after the last date in the

observation period. More timely reports might be developed if data submissions are required twice a year, six months after the end of the claims period.

3. **Measurement Topics:** A Limited Geographic model allows the health care reform effort to focus on the commercial and self-insured markets that cover nearly half of all state residents and that are important “levers” in changing health care cost trends. These health care utilizers have proximity to the road system and may choose among providers. Employers in this area are also very concerned about rising health care premiums and cost.

The data offers the potential for in-depth analysis of care patterns, trends in utilization and cost, and outcomes for providers. Well-defined geographic areas ensure that the claims costs for all the residents in a particular area are submitted by the health plans. At the early stages, Alaska should draw as wide a net as possible to ensure that all the paid claims for insured individuals reach the APCD. The data derived from a Limited Geographic Area model will support analysis of alternative payment models, utilization patterns and trends in cost for specific services (procedure codes).

4. **Resource Investment:** A limited geographic model would be slightly less costly than a distributive model because a smaller number of datasets would need to be acquired, cleaned and managed.
 - a) Developing a reporting and data release plan: At the outset, the APCD planning process should include time and resources to conduct a use case inventory and a data and reporting plan. In other states, this process is more effective when stakeholders participate in the development process. This reporting plan sets expectations about what will be forthcoming and establishes ground rules about use of the data. At an early stage, this process builds collaboration among stakeholders and APCD Administrators. The process helps frame the design and prioritization of the downstream reports.
 - b) Obtaining data: Steps to acquiring this data after obtaining legal authority include developing a technical specification (a data submission guide); building a central repository; and managing the actual data transfer process. Most APCD states hired experienced data management vendors to bring the collection process on line, including initial data checking and review.
 - c) Storing data: The model for storing ongoing intake and production files varies from state to state. A data management vendor would securely warehouse the data and build the appropriate file structures to support reporting and analysis. Final versions of APCD analytic files could be housed in a state run data warehouse, preferably one with advanced business intelligence tools to provide annual reporting, benchmarking, and policy data.
 - d) Analyzing data: Once the analytic infrastructure and process is established, running the reports, producing write-ups, and creating the public presentation would require analytic, writing, and graphics design support. Other important

requirements include “value-add” tools such as inpatient groupers and risk adjustment tools in the base analytic capacity.

Estimated Cost Table 3: Limited Geographic Model			
Task	One Time Start Up Cost	On Going Annual Cost	Assumptions
Data collection	\$100,000	\$50,000 - \$100,000	Four commercial carriers provide data directly to state; start up includes designing intake model
Analytic and policy studies	\$125,000	\$50,000- \$150,000	Includes report design and analytic tools. Dependent on number, frequency and complexity of reports
System Maintenance	\$125,000	\$20,000 - \$100,000	Low end assumes leveraging Medicaid data warehouse capacity at minimal cost for data storage; upper end is contracted entity.
Overhead and Process Management	\$50,000	\$75,000 - \$150,000	State staff to manage the data acquisition process; oversight of technical issues and project management; health plan communications; data release management.
TOTALS	\$400,000	\$195,000- \$500,000	

5. Timing:

- a) Obtaining the data: The timeframe between statutory authorization and initial data collection is usually 12-16 months due to regulatory process requirements; confirming funding sources; and allowing six months for health plans to come into compliance. States are beginning to shorten that timeframe as more examples of legislation, regulation and data submission guides are developed.
- b) Analyzing the data: Once the analytic methodology has been established (including data validation processes), creating the measurements would require one to two months. Additional time would be needed for pre-release review with stakeholders to explain methodologies and interpret results.

Summary Table 3: Limited Geographic Model	
Strengths	Limitations
<ul style="list-style-type: none"> • Supports analysis of health care reform efforts that affect employers and taxpayers in the state's most populous areas, approximately 80% of the state's total population • Legislation, regulation and public oversight creates shared expectations about how reports will be developed, vetted and published • Data supports robust analysis of utilization and cost for most of the health care spending • Allays concerns about reporting and protected health information for providers and patients in less densely populated areas • Easier to engage medical community in a more compact geographic area • Statistical models can extend analysis to the rest of the state 	<ul style="list-style-type: none"> • Similar level of effort as for a "full" state-wide APCD • Population health studies based on this data model could explore issues in more urban areas. Information about outlying areas may be limited, depending upon success of negotiations with federal payers • APCD planning process needs to be aligned with Medicaid Data Warehouse replacement project goals and timeline • No uninsured data is available

E. Option 4: All-Payer Claims Database

1. **Description:** This option describes an approach that is similar to that used in the other existing, mandatory submission states, including obtaining statutory authority, developing and promulgating regulations, and hiring a vendor to collect and manage the data.
2. **Potential Data Sources:** Most states opt for a mandatory APCD governed by statute and rule making authority. The legislative direction allows health plans to disclose protected health information under the public health authority exemption of HIPAA. In addition, the state Medicaid program and self-insured state employee programs would be required to submit data. State regulatory authority creates an obligation for health plans to submit data in a certain format on an established timeline, with potential fines or penalties to encourage compliance. Statute and regulation also define how the data will be used, by whom and at what level of detail. In contrast, voluntary APCDs are primarily regional collaborative efforts operated by private non-profit organizations. Access to the data is limited to participating providers or subscribers.

In addition to commercial health plans, the state Medicaid program and self-insured state employee programs would be required to submit data.

In order to see the full portrait of cost of care, federal spending should be included in the APCD. In Alaska's unique health care environment, several federal agencies provide health care services to at least one quarter of Alaska's residents. Medicare, Indian Health Service, Federal Employees, Veterans Affairs, and TRICARE are active health care providers and payers. Here, Alaska has an opportunity to be a national leader for other states by working with these federal agencies. This effort would build on encouraging recent developments for APCDs. CMS recently created a new State Agency Data Request Program¹² for Medicare files that may be combined with other files such as APCDs. In addition, Oregon's APCD has requested and received data from the Indian Health Service, also an important health care payer in Alaska.

3. **Measurement Topics:** Of all the options presented in this report, a full APCD data collection and reporting process presents the most comprehensive, robust data and associated analytics, reporting, and modeling that can support health care improvement. With an APCD, Alaska will be able to compare and contrast health care trends for different population groups, including demographics, disease condition and use of different types of care. Alaska's diverse geography, distinct populations and unique provider landscape are unusual; other states may not be suitable benchmarks. An Alaskan APCD has the clear advantage of letting Alaska measure its progress and change against its own history and backdrop, eliminating the need to make adjustments for Alaska's environment. Specific topics relevant to the Alaska health care system include:
 - a) Population health analysis;
 - b) Price analysis;
 - c) Health care reform scenarios and sensitivity analysis;
 - d) Benchmarking against state-specific, risk adjusted quality metrics;
 - e) Monitoring health trends at a level of meaningful specificity; and
 - f) Exploring high value health care and payment reform.
4. **Resource Investment:** The estimated implementation cost of a standalone APCD depends largely on the number of distinct data feeds and the types and frequency of analytic reports that are produced. Rhode Island's APCD (1M residents; 800,000 covered lives) will have data feeds from four commercial health plans, Medicare and Medicaid. The cost of data intake alone is approximately \$500,000 for startup, and approximately \$300,000 annually. New Hampshire, with 1.6M residents and 1.42M covered lives, has a contract for \$1.4M for a three-year term with data feeds from 26 commercial health plans and Medicaid.

¹² <http://www.resdac.org/cms-data/request/state-agency>

An Alaska APCD could build upon the new Medicaid data warehouse and any related analytic tools created during the next three to five years. Examples include:

- Creating and maintaining a single secure location for sensitive health care data;
- Avoiding redundant file creation and project oversight services;
- Streamlining data quality processes;
- Building standardized specifications for analytics; and
- Centralizing data distribution and reporting functions.

A data warehouse can be partitioned to create a completely separate environment for the APCD. This arrangement would maximize use of the existing infrastructure as well as the technical expertise that will be available during a data warehouse design and implementation effort. In doing so, Alaska would be able to pilot new options for aligning APCDs with state based disease and treatment registries.

A third option for an Alaskan APCD is to partner with another, fully operational state APCD. As more states bring APCDs on board, smaller states like Alaska may have an opportunity to use excess capacity in other states' APCDs. The existing APCD, in partnership with its data management vendor, could partition its data processing and warehousing environment to create a separate warehouse for Alaska's smaller volume of claims data. An arrangement of this type could shorten the startup and implementation timeline and reduce startup costs.

Regardless of the technology platform that Alaska might select, resource need is similar to that identified for the Limited Geographic area APCD. The major areas of investment include:

- a) Developing a reporting and data release plan: At the outset, Alaska's APCD planning process should include time and resources to conduct a use case inventory and a data and reporting plan. In other states, this process is more effective when stakeholders participate in the development process. This reporting plan sets expectations about the path of development and data use governance. This process builds collaboration among stakeholders and APCD Administrators and helps frame the design and prioritization of the reports.
- b) Obtaining data: Similar to a Limited Geographic Model, a Statewide APCD would also develop a technical specification (a data submission guide); build or hire a vendor to manage a central repository; and manage the actual data transfer process. Most of the APCD states have hired experienced vendors to manage this process.
- c) Storing data: Alaska's Medicaid Data Warehouse could be partitioned to accommodate this data. Business Intelligence tools scheduled to come on line in 2016-2017 would provide the analytic tools needed to develop the measurements for annual reporting. In the interim, an outside entity could store the data and develop the analytics and report methodology.

- d) Analyzing data: Once the analytic infrastructure and process is established, running the reports, producing write-ups and creating the public presentation would require analytic, writing and graphics design support. The base analytic capacity includes “Value-add” tools such as inpatient groupers and risk adjustment tools.

Estimated Cost Table 4: All Payer Claims Database			
Task	One Time Start Up Cost	On Going Annual Cost	Assumptions
Data collection	\$300,000	\$200,000 - \$300,000	Four commercial carriers provide data directly to state Medicare Data Fees Medicaid Data Extract Programming
Analytic and policy studies	\$125,000	\$50,000- \$250,000	Dependent on number, frequency and complexity of reports
System Maintenance	\$125,000	\$20,000 - \$200,000	Low end assumes Medicaid data warehouse at minimal cost; upper end is contracted entity.
Project Management	\$100,000	\$75,000 - \$150,000	Resource at the state to manage process and provide oversight of technical issues and project management; Data Release; Health Plan Communications
TOTALS	\$650,000	\$345,000- \$900,000	

5. **Timing:** States’ experience in establishing a mandated APCD has varied. Excluding the time needed to pass legislation, generating data and reports could begin approximately 16 to 24 months after legislative approval and identification of funding for a data management vendor. System development time will be longer or shorter depending on the data vendor’s experience with claims data collection from multiple payers.

Summary Table 4: All Payer Claims Database

Strengths	Limitations
<ul style="list-style-type: none"> • Single most complete and flexible data source to support health system improvement, able to provide inputs that are not available from any other source • Legislation, regulation and public oversight creates shared expectations about how reports will be developed, vetted and published • Small number of private carriers streamlines data intake; three largest are national carriers that are familiar with APCD submission processes in other states • Integrates Medicaid and Medicare data • Opportunity to lead the nation and work with federal agencies that have not yet submitted data to APCDs, e.g. VA • Begin with high-level public health analyses • Opportunity to generate state-specific, high quality information through a standardized intake process with rigorous data quality standards 	<ul style="list-style-type: none"> • Expectations for data availability can outpace even an aggressive APCD development timeline; payment reform may need to move more quickly • State experience with health care data for use in policy analysis has been limited by older, outdated systems; capacity will develop over time • Short time frame each year for legislative action (four month session begins in January) • Uncertainty about the Medicaid Data Warehouse timeline could affect a joint effort • Data from Federal agencies other than Medicare will require negotiation • No uninsured data would be available • At the higher end of cost compared to the other options

VII. DISCUSSION OF THE OPTIONS

A. Evaluation Criteria

A new data collection and reporting initiative, APCD or otherwise, is a major investment in time, financial resources and stakeholder collaboration. Based on the experience of other APCD states, as well as other new health data resources, evaluation criteria are helpful in comparing and contrasting the different options. The following questions have been selected to highlight the key issues that emerge during development and implementation.

- Does the option directly and comprehensively accomplish the primary goal of providing information about health care cost and utilization that supports upcoming health system modeling and analysis efforts?
- Are there any legal, financial, political or technological barriers to implementation that are more difficult to overcome than for other options?
- Is the option cost effective, providing sufficient data at a reasonable level of investment?

Table 5 summarizes findings for the four options that the FHC identified. Each item is ranked Low, Moderate or High relative to the questions in the left hand column. Note that all four options share some common characteristics:

The Uninsured: None of the options provides a clear route to obtaining information on care delivered to the uninsured population. Some information may be available in the HDD that could provide insight into how the uninsured use secondary or tertiary care, however, data about outpatient and community-based care will not be reported.

Reporting Plan: Regardless of the data source, a clear vision will need to be developed to determine what aspects of the health care system to measure. Successful APCDs—those that win support, collect robust data and issue regular, meaningful reports – articulate a clear set of principles for the use and guardianship of the data. States with these APCDs have built upon prior experience with HDD data sets and established a foundation of trust and expertise. In addition, stakeholders engaged in extensive discussions about how to guide decisions about access to the data and permitted uses. These conversations are critical underpinnings to building a data-driven mindset among important members of the stakeholder community.

Data driven decision-making: The APCD or a precursor option could provide reports and analytics that may lead to hard choices. Using the reports and outputs from any data source will help set the tone for informed decisions.

Alaska has some challenging decisions to make in regards to an APCD or other data option. Ultimately, any of the identified options will take the state further along the roadmap towards greater data transparency in an effort to inform and involve health care stakeholders about health care cost, utilization, and care patterns.

Table 5: Evaluation Grid				
Criteria	Option 1 Repurpose Existing Data	Option 2 Distributive Model	Option 3 Limited Geographic Model	Option 4 All Payer Claims Database
Capacity to support Alaska's modeling and analytic needs	<ul style="list-style-type: none"> • Very low • Statewide or summary level data lacks detail; Hospital Discharge data is incomplete; other data is too highly aggregated to support modeling and analytics 	<ul style="list-style-type: none"> • Low to Moderate • Voluntary data submission limits the level of detail for inputs into models and analysis 	<ul style="list-style-type: none"> • High • Focus on highly populated areas; ongoing data collection for trend monitoring and analysis 	<ul style="list-style-type: none"> • High • Fully supports advanced modeling and analytic techniques, including sensitivity analysis, population health, and trends monitoring and analysis
Are there any legal, financial, political or technological barriers to implementation that are more difficult to overcome than for other options?	<ul style="list-style-type: none"> • Moderate • HDD: Obtaining data from all hospitals • Federal data negotiations • Analyzing and reconciling metrics based on different data sources 	<ul style="list-style-type: none"> • Moderate/High • Negotiating data agreements • Federal data negotiations 	<ul style="list-style-type: none"> • High • Obtaining legislative authority • Addressing privacy and confidentiality concerns • Creating mutually trusting relationships that support open conversation about options for health system change • Obtaining start up resources and maintaining the investment 	<ul style="list-style-type: none"> • High • Obtaining legislative authority • Addressing privacy and confidentiality concerns • Creating mutually trusting relationships that support open conversation about options for health system change • Obtaining start up resources and maintaining the investment
Cost effectiveness, providing sufficient data at a reasonable level of investment?	<ul style="list-style-type: none"> • Low investment • Least useful model for modeling and analytics 	<ul style="list-style-type: none"> • Moderate resource /low to moderate utility • Moderate investment that does not greatly expand additional modeling and analytic capacity over Repurposed Data 	<ul style="list-style-type: none"> • High resource/ moderate utility • High investment; better modeling and analytics than Repurposed or Distributed models; leaves out data for rural, underserved state residents 	<ul style="list-style-type: none"> • High resource/ High utility • Highest investment with the advantage of the most flexible opportunities for modeling and analytics for state residents in all areas of the state

APPENDICES

Appendix A: List of Persons Contacted

Insurance Carriers	
Name	Affiliation
Bernie Inskeep	United HealthCare Insurance Company
Carolyn Callopy	United HealthCare Insurance Company
Cecil Bykerk	Alaska Comprehensive Health Insurance Association
Charlie Parks	Premiera Blue Cross/Blue Shield of Alaska
Grace Flux	United HealthCare Insurance Company
Jeff Davis	Premiera Blue Cross/Blue Shield of Alaska
Jeff Toda	United HealthCare Insurance Company
Jessica Sutin	United HealthCare Insurance Company
Kristin Thomas	Connecticut General Life Insurance Company/Cigna
Mary Taylor	Aetna Life Insurance Company
Megan M O'Halloran	Time Insurance Company
Mike Hampton	Golden Rule Insurance Company
	Celtic Insurance Company
	John Alden Life Insurance Company
	ODS Health Plans, Inc.
	Trustmark Insurance Company

Insurance Brokers	
Name	Affiliation
Bill Hunsuck	Alaska Association of Health Underwriters/Wilson Agency
Greg Loudon	Parker, Smith & Feek
Jeff Ranf	Wallace Insurance Group
Juna Penny	Alaska Association of Health Underwriters/Providence
Lon Wilson	The Wilson Agency
Michael Humphrey	The Wilson Agency

State: SoA Employee/Retiree Health Plan; SoA Insurance Regulator, Medicaid	
Name	Affiliation
Becky Hultberg	Commissioner, AK Department of Administration
Bret Kolb	Director, Alaska Division of Insurance
Commissioner Bill Streur	Alaska DHSS Commissioner
Jim Puckett	Director, Alaska Division of Retirement & Benefits, DoA
Kim Poppe-Smart	Deputy Commissioner, AK DHSS
Margaret Brodie	Director, Division of Health Care Services, AK DHSS
Mike Barnhill	Deputy Commissioner, AK Department of Administration

Appendix A: List of Persons Contacted

Public Purchasers/Insurers	
Name	Affiliation
Alexander Spector	Director, Alaska VA Healthcare System
Christopher Mandregan	Area Director, AK Area Native Health Service/IHS
Iris Gray	Director, Contract Health, Alaska Native Medical Center
	UnitedHealth Military & Veterans Svcs (TRICARE W Reg)
Employers/Employer Interests/Union Trusts	
Name	Affiliation
Bill Popp	Anchorage Economic Development Corporation
Cathie Roemmich	Juneau Chamber of Commerce
Debi Hansen	Public Employees Local 71 Trust Fund
Dennis McMillian	The Foraker Group
Fred Brown	Health Care Cost Management Corporation of Alaska
J.J. Harrier	Anchorage Chamber of Commerce
Janece Higgins	General Manager, Alaska Rubber & Supply, Inc.
Janet McDaris	Greater Fairbanks Chamber of Commerce
Kathie Wasserman	Alaska Municipal League
Kathy Carr	VP for Human Resources, GCI
Kevin Thomas	VP and CFO, NANA Regional Corporation, Inc.
Lydia Garcia	Administrator, NEA-Alaska Health Plan
Mary Quin	President, NMS
Megal Collie	Alaska AFL-CIO
Michael Williams	ASEA/AFSCME Local 52 Health Benefits Trust
Patrick McCullough	Administrator, Masters, Mates & Pilots Plans
Patti Janusiewicz	Alaska Electric Trust Funds (IBEW)
Rachel Petro	Alaska State Chamber of Commerce
Rhonda Kitter	Chief Financial Officer, NEA-Alaska Health Plan
Tammy Green	Providence Health & Services
Tim Adamczak	Comp/Benefits Mgr, Alyeska Pipeline Service Company
Hospitals, Community Health Center	
Name	Affiliation
Annie Holt	Alaska Regional Hospital
Bruce Lamoureux	Providence Health & Services
David D'Amato	Alaska Primary Care Association
Jeannine Monk	Alaska State Hospital & Nursing Home Assn.
Karen Perdue	Alaska State Hospital & Nursing Home Assn.

Appendix A: List of Persons Contacted, continued

Tribal Health System	
Name	Affiliation
Douglas Eby, MD	Southcentral Foundation
Katherine Gottlieb	Southcentral Foundation
Lanie Fox	Alaska Native Health Board
Myra Munson	Sonosky, Chambers, Sachse, Anderson & Perry
Roald Helgesen	Alaska Native Tribal Health Consortium
Steve Tierney, MD	Southcentral Foundation
Valerie Davidson	Alaska Native Tribal Health Consortium

Physicians	
Name	Affiliation
Brenda Moore	Christian Health Associates
George Rhyneer, MD	Alaska Physicians & Surgeons
Harold Johnston, MD	Alaska Family Medicine Residency
Jody Butto, MD	American Academy of Pediatrics, Alaska Chapter
John Bundtzen, MD	American College of Physicians, Alaska Chapter
John Cullen, MD	President, AK Academy of Family Physicians
Kris Rahm	American College of Physicians, Alaska Chapter
Laura Hudson	Alaska Physicians & Surgeons
Lynn Spivey	American Academy of Pediatrics, Alaska Chapter
Marilyn Dodd	Alaska Academy of Family Physicians
Mary Ann Foland, MD	Past President, AK Academy of Family Physicians
Michael Haugen	Alaska State Medical Association
Stephanie Monahan	All Alaska Pediatric Partnership
Tom Nighswander, MD	WWAMI Alaska

Other Health Care Providers	
Name	Affiliation
Christine Potter	Alaska Nurse Practitioner Association
Debbie Thompson	Alaska Nurses Association
Jerry Jenkins	Anchorage Community Mental Health Services
John Riley, PA-C	Medex Northwest/UAA
Nancy Davis	Alaska Pharmacists Association
Tonie Marie Quaintance	Alaska Psychological Association
Yvonne Chase	Alaska Behavioral Health Association
	Alaska Dental Society
	Alaska Nurse Practitioner Association
	Alaska Psychiatric Association

Appendix A: List of Persons Contacted

Consumers	
Name	Affiliation
Jeffrey Mittman	ACLU of Alaska
Ken Osterkamp	AARP Alaska
Lanie Fox	Alaska Native Health Board
Mark Regan	Disability Law Center of Alaska
Nikole Nelson	Alaska Legal Services Corporation
Patrick Luby	AARP Alaska

Public Health Experts	
Name	Affiliation
Alice Rarig	Section of Health Planning & Systems Development, DPH
Andrea Fenaughty, PhD	Section of Chronic Disease Prevention & Health Promotion, DPH
Charles Utermohle	Section of Chronic Disease Prevention & Health Promotion
Duane Mayes	Division of Senior & Disability Services
Jill Lewis	Division of Public Health
Joe McLaughlin, MD	Section of Epidemiology, Division of Public Health
Kathy Allely	Section of Chronic Disease Prevention & Health Promotion, DPH
Melissa Stone	Division of Behavioral Health
Patricia Carr	Section of Health Planning & Systems Development, DPH
Phillip Mitchell	Bureau of Vital Statistics, DPH
Stephanie Wrightsman-Birch	Section of Women's, Children's & Family Health, DPH

Community Planners	
Name	Affiliation
Allison Fong	Providence Health & Services
Delisa Culpepper	Alaska Mental Health Trust Authority
Diane Kaplan	Rasmuson Foundation
Elizabeth Ripley	Mat-Su Health Foundation
Joel Neimeyer	Denali Commission
Kate Burkhart	Health & Social Services
Michele Brown	United Way of Anchorage
Nancy Merriman	Denali Commission
Tom Chard	Alaska Mental Health Board
Wayne Stevens	United Way of SE Alaska

Appendix A: List of Persons Contacted

Researchers	
Name	Affiliation
David Driscoll, PhD, MPH, MA	Institute for Circumpolar Health Studies
Dr. Jeff Bailey	Center for Behavioral Health Research & Services, UAA
Heather Hudson	Institute for Social & Economic Research
Jan Harris	College of Health & Social Welfare, UAA
Mark Foster	Mark A Foster & Associates
Rosylind Frazier	Institute for Social & Economic Research
Scott Goldsmith	Institute for Social & Economic Research



Introduction to All Payer Claims Databases

Prepared for

**Alaska APCD Business Case Assessment, sponsored by
Alaska Health Care Commission**

Prepared Date
09/10/12

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I. INTRODUCTION

Total health care spending in Alaska reached \$7.5 billion in 2010, an increase of 40 percent since 2005¹ posing significant economic and public policy concerns. The Alaska Health Care Commission first established by executive order in 2009, and re-established by statute in 2010, is mandated to advise the State on policies for improving health and health care for all Alaskans. The Commission meets quarterly and has 14 members including representatives of the Department of Health and Social Services, hospital leadership, the primary care physician community, the health insurance industry, the military/VA health sector, the tribal health system, consumers, and legislators, among others. The Commission initially created a strategy for building a plan to transform Alaska's health care system.

This strategy includes the following steps:

- I. Develop a vision of the ideal health care system
- II. Study current health care challenges to inform policy recommendations
- III. Build the foundation of a strong health care system
- IV. Develop policies that enhance the consumer's role in health and health care
- V. Measure progress

The Commission has articulated a number of recommended solutions for improving the health care system in Alaska. The solutions include:

- Ensure the best available evidence is used for making decisions
- Enhance quality and efficiency of care on the front-end
- Increase price and quality transparency
- Pay for value
- Build the foundation of a strong health care system
- Focus on prevention

These solutions require access to and the use of timely, accurate health care utilization, cost and quality information. For example, information is important to ensuring that the best available evidence is used by providers and patients in health care decision-making. Moreover, information is critical to increase price and quality transparency that will help educate consumers, providers, and policymakers about health care costs and quality.

The Alaska Health Care Commission has begun to explore options for gathering the necessary data to continue to implement the proposed solutions in order to achieve its goals. Freedman HealthCare is assisting the State with a study to assess the feasibility of establishing an All Payer Claims Database (APCD) or other comparable data system in Alaska. The goals of the study are: 1) to learn more about current data collection efforts in Alaska and where gaps exist; 2) to hear from stakeholders their ideas regarding how detailed utilization and cost data could be used to

¹ Alaska Health Care Commission, 2011 Annual Report Highlights

constrain costs and improve quality in Alaska and what are the barriers to collecting and using these data; and 3) to propose ideas for managing and sustaining a data collection system in the State. This briefing document provides an overview of APCDs. It discusses not only what they are and where they have been established, but how the data have been used, and the lessons learned from other states. Briefings will be scheduled over the next several weeks to hear from stakeholders their thoughts regarding how an APCD or other comparable data system can help fulfill Alaska's vision of ensuring a health care system that produces improved health status, provides value for Alaskan's health care dollar, and delivers consumer and provider satisfaction.

II. BACKGROUND

Most states collect hospital discharge data that typically include statewide all-payer data for inpatient hospital stays. These data provide important population-based information including patient demographics, diagnoses and procedures for inpatient stays. However, as more care has moved to outpatient settings, these data are quite limited in assessing the costs and quality of a state's health care system.

All Payer Claim Databases (APCDs) were designed to address a need for comprehensive information about health and healthcare across all settings of care. The motivations for collecting this data include informing efforts around cost containment and quality improvement, assessing access or barriers to care, studying utilization patterns, and informing policy decisions.

Every health encounter creates a claim for payment. Both public and private insurance plans routinely aggregate these claims data into their own administrative databases. APCDs combine data from all payers in a state, providing statewide information on costs, quality, and utilization patterns. The payers include Medicare, Medicaid, private insurers, dental insurers, children's health insurance and state employee benefit programs, and self-insured employer plans. The databases generally include data on eligibility; medical, pharmacy, and dental claims; and provider information. As with all data sets, there are limitations with APCD data, but capturing information from most - if not all - of the insured encounters in a state can create a powerful information source.

APCDs may be governed in a variety of ways, ranging from entirely public entities (housed in a state agency), a private entity (such as a non-State non-profit organization), or a hybrid model combining the two. Data submission can occur either as a statutory/regulatory mandate (requiring all payers to contribute data by law), or voluntary efforts.

III. POTENTIAL BENEFITS

How can APCDs be useful?

Large claims data sets, such as APCDs, can be used by a number of different stakeholders within a state for various purposes. Comprehensive information on disease incidence, treatment costs, and health outcomes is essential for informing and evaluating state health policies. These data can be used to give consumers the tools to begin to take a more active role in their health and health care and to make more informed decisions. Providers and payers can use these data to improve quality and develop appropriate payment policies. As discussed earlier, a growing number of states are developing APCDs. Below is a brief discussion on several ways APCDs can and have been used in states by various stakeholders.

Public Reporting on Price and Quality of Health Care Services

An APCD can be used by public or private entities to increase transparency in cost and quality data. Two states that have used the APCD in this way are Massachusetts and New Hampshire. The Massachusetts [“My Health Care Options”](#) website displays cost and related quality measures for a limited set of hospital-based procedures. Consumers are able to search by provider name, condition or procedure, or a radius around a particular zip code. This website provides explanation and detail at three levels: summary ratings with one to three dollar signs and stars; a second screen with detail about the quality rating, and a third level showing the cost measures and comparisons to statewide benchmarks. The [New Hampshire Health Cost](#) website uses APCD information to generate an estimated cost of a procedure by facility. Using additional information provided by insurers, the tool uses the consumer’s deductibles and co-pays to show the consumer’s estimated total cost, as well the precision of the estimate.

Clinical Performance Improvement

Large claims databases offer important opportunities to identify high performing clinical groups and learn how high quality, effective clinical and systems deliver care. APCDs seek to build a longitudinal portrait of each individual’s claims. This data provides a strong foundation for standardized metrics that help clinicians identify promising practices for improving care. In Minnesota and Colorado, APCD data will be used to provide cross-payer quality reports that allow providers to look at performance across the entire practice, eliminating the need to read and interpret reports from all their payers. Voluntary data collection organizations - the Wisconsin Health Information Organization and the Puget Sound Health Alliance in Washington state - offer provider specific, cross-payer quality data. In Rhode Island, the Rhode Island Quality Institute is collecting claims data to evaluate the effect of the federally funded Beacon Community Program on provider practices, with particular emphasis on the effect of electronic medical records and other practice-level technology investments.

APCDs in Colorado, Connecticut and New York are building capacity to align claims-based quality information with outcome results drawn from health information exchanges (HIE). To accomplish this vision, designers are building processes that uniquely identify each individual in the APCD so that other data sets can use the same processes to facilitate matching. Analysis drawn from both data sources supports clinical effectiveness research to identify best practices.

Information on Health Care Quality and Cost Trends for Public Policy Decision Makers

A number of states have used data from an APCD to provide additional analyses on quality and cost trends to inform public policy decision makers. Maine has used its database extensively to document the cost of certain adverse health events and evaluate the effectiveness of a medical homes pilot, while New Hampshire constructed a comprehensive health care information system that allows a user to analyze any number of health system questions. Vermont has used its APCD for an expenditure analysis by type of service and several studies on provider reimbursement for primary care services have also been conducted. Massachusetts also has conducted extensive analyses on its health care system using a large multi-insurer claims database. Studies have included variation in cost by provider, quality trends, and trends in utilization of various health care services.

Studying Geographic Variation

Public program administrators want to understand patterns of utilization and the value of care delivered to a given population in a geographic region. One of the best examples of work in this area is the [Dartmouth Atlas of Health Care](#). Using one of the largest health care claims databases (Medicare), the Dartmouth Atlas has documented significant differences in how elderly Americans use health care resources, and the influence of the local supply of health care resources on the rates of use. An important discovery about geographic variation is that differences in spending across regions do not correlate with health outcomes. While patients in high spending regions receive more health care, several studies have found that those regions do not achieve better outcomes. In fact, in several studies, higher spending regions were associated with poorer outcomes. An APCD that includes Medicare, Medicaid and private payer data extends the Dartmouth lens and helps examine the total cost of care for similar patients regardless of payer and reimbursement methodology. Such data eliminates “quality silos” of past studies and supports a more robust conversation about care delivery strategies.

Population Health Analysis for Public Health Officials

APCDs could dramatically alter the analyses conducted by public health programs to develop, evaluate and report on the impact they have on their targeted, and oftentimes underserved, communities. This impact could include direct cost savings and cost benefit analysis resulting from specific program interventions. In general, the data included in an APCD can address crucial surveillance and monitoring gaps that exist across programs within a state and can be used to:

- estimate prevalence of disease/condition;
- assess standards of care for disease/condition;
- examine the financial impact of disease/condition; and
- evaluate program impact.

Other examples include:

- Supplementing existing public health surveillance reports with expanded measures of morbidity using claims, pharmacy, and product file data. Current surveillance reports

focus on outcomes such as mortality, self-reported illness, hospitalization, and cancer incidence. Using APCD data could assist in more fully understanding the spectrum of population-based illness in Alaska.

- Using pharmacy claims data for targeted monitoring of the quality of primary care and nursing home medication management in the elderly; identify inappropriate prescription patterns, preventable adverse effects and the association of such effects with preexisting conditions.
- Assessing patterns of overuse of various medical services including imaging.
- Developing measures about the effect of specific chronic conditions on health care cost and utilization.

IV. KEY MILESTONES IN DEVELOPING AN APCD

The implementation process for an APCD or any similar, new health data system requires some preliminary steps before data is collected. While the milestones listed below are sequential, preparation and background work can happen concurrently.

APCD Advisory Board (or similar group): This group of varied stakeholders should be created and convened to identify internal (within State) and external stakeholders; create sub-committees to address specific issues, such as technical requirements and data use policies; and make recommendations or decisions on next steps.

Data Collection Authority: A state needs to determine its legal ability to ask payers to submit data toward the APCD, either through legislation or executive order. This will determine key aspects of organization and data collection permission, such as the entity in charge of administering the APCD and the state's stance on the collection of personal identifiers.

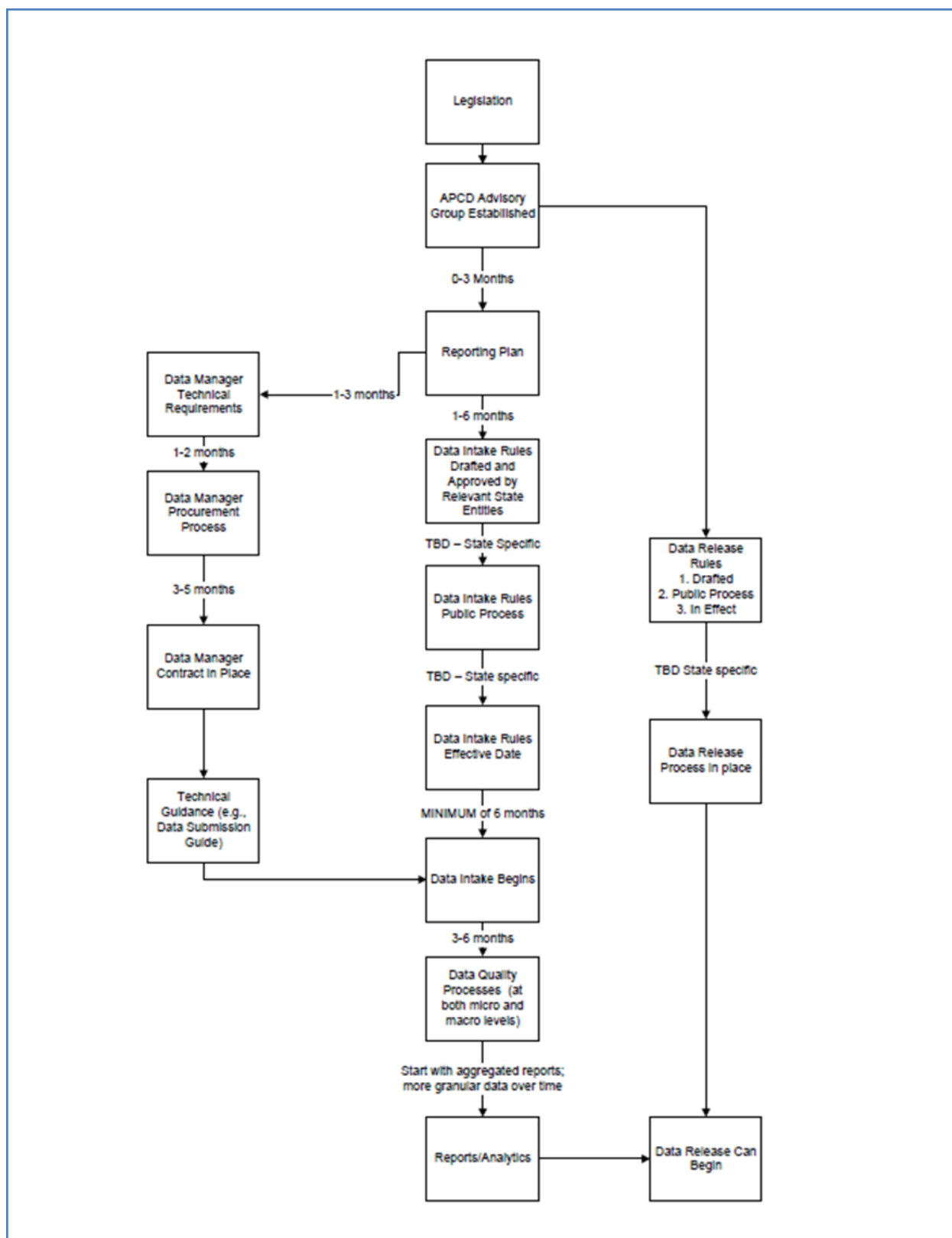
Data Collection Rules: Once authority has been established, a state needs to define some technical parameters for its APCD. The creation and release of regulations and/or a Technical Submission Manual for payers will identify all data submitters in the APCD and the format by which it is received. For example, some important decision points in this process may be whether or not to include Pharmacy Benefit Managers (PBMs) as mandatory submitters; a plan to receive Medicare data; identifying the number and types of claims files a payer should submit (Medical, Pharmaceutical); a schedule for regular data submission.

Data Release Rules: A vision and plan for data release should ideally be the conversation driver in implementing an APCD. When there is an intended purpose for the data, the state will be more easily able to identify specific audiences and consumers, and therefore determine level of access to the data at varying levels, if desired. Much of this would be encompassed in a state's APCD regulations.

Technical Build: When a state has authority, collection rules, and release standards in place, the data submission can begin. In the beginning stages of data submission there will be a need for rigorous data quality checks and feedback with payers to ensure accuracy. A state may choose

to engage an outside vendor to assist in carrying out APCD implementation at various levels: advisement; data collection, cleaning, and warehousing; data analytics and report production; data access and delivery mechanisms.

The graphic on the following page depicts a typical APCD implementation road map:



V. LESSONS LEARNED

Each state's APCD is different, emerging from their particular vision about health care quality, measurement and value. Yet, over the past five years, several universal themes have emerged from APCD states as they have undertaken the development and implementation process.

Convene a broadly representative stakeholder group to provide advisement during the development and implementation phases. The Tennessee Health Information Committee, Colorado APCD Advisory Committee, and Oregon Health Authority demonstrate the value of diverse stakeholders providing guidance and oversight to operations entity; serving as “ambassadors” to peers and colleagues; championing the value an APCD to skeptics; and offering important insight to data reporters, data users, and those being measured.

Legislative authorization and clear regulatory guidance improve the quality and breadth of APCDs. A standardized set of data submission rules allows the APCD authority to streamline construction of the database. Legislation identifies the types of insurance carriers and providers that are required to submit and provides the APCD administrator with clear public health authority to collect data. In the early years of APCDs, regulatory language often included detailed field specifications and instructions to the data submitters. More recently, however, legislation has shifted to empower an advisory group to help shape the regulations around data intake and release.

Establish clear criteria for permitted uses (“releases”) of the APCD data. Including diverse stakeholders in the decision making process will help determine whether a request for the data is consistent with the state's expressed policy. Colorado, Massachusetts and Oregon have established broad-based data release bodies. New Hampshire, Maine and Massachusetts post applications for APCD data and allow for public comment prior to review.

Work closely with health plans from the start. It is critical that APCDs work closely with health plans as the key data submitters to develop data intake specifications and regulatory requirements, especially given the challenges and limitations of claims payment systems. Health plans have urged states to allow between six and nine months' lead time before data submission begins.

Create a tiered or phased approach to reporting. Similar to other complex datasets with multiple years of data such as Hospital Discharge Datasets, APCDs have become more robust over time. As data submitters improve compliance, the APCD can offer more highly aggregated population reports to demonstrate proof of concept and to identify areas in need of further quality efforts. Creating a tiered approach allows the state to use preliminary reports to set the stage for more detailed examinations of health care service and utilization in the future. Tennessee and Colorado are two states that have successfully used this approach.

Embrace transparency. Successful APCDs have a “no surprises” policy for issuing public reports that include comparisons across settings or providers. In Massachusetts, for example, the

methodology for evaluating variation in cost for selected services was shared first with hospitals to allow time for public comment before results were published on a consumer-facing website.

Create a sustainability plan to cover data intake and reporting functions. APCDs typically require a large start-up investment of time and resources before any reports can be delivered. To realize the return on investment, effective APCD planning includes a strategy for creating ongoing revenue to support operating costs. Most APCDs have been supported by state appropriations; Tennessee and New Hampshire, for example, received operations support from Medicaid funding. APCDs currently in development in Rhode Island, Connecticut and New York were awarded startup funding from Exchange establishment grants and will develop on-going funding strategies as part of the implementation process. The Colorado APCD received no state appropriations and successfully obtained startup funding through grants and foundation funding; later, data use fees and contracts with state agencies will provide ongoing support.

Build a unique member ID to set the stage for aligning with other data sources. One of the goals of an APCD is to create a person level, longitudinal portrait of care for use in diverse reporting options. Advanced technological matching processes allow APCDs to assign a unique identifier that is consistent within and across payers' records. The unique member identifier can also be created from clinical records and lab results. Using this member identifier, the APCD can support clinical effectiveness reviews, cross payer quality reports and outcomes research.

Robust privacy and security measures are essential. An APCD must achieve and maintain the highest levels of security around protected health information. Current security standards call for encryption at motion and at rest. Whether the data manager is a contracted vendor or an in-house operation in a state agency, the APCD must demonstrate the same or greater protections than the health plans maintain.

VI. NEXT STEPS

In conjunction with the Alaska Health Care Commission, Freedman HealthCare will host and conduct stakeholder information sessions to supplement this briefing paper. The State welcomes any feedback and invites you to participate in the question and answer session following the presentation either in person, via webinar, or separately contacting the Freedman HealthCare team via email, (ptrivedi@freedmanhealthcare.com). Gathered stakeholder responses will be presented at the Health Care Commission meeting on October 11, 2012.

Appendix C: Stakeholder Interview Tool

General:

- How much do you know about APCDs?
- Where do you see Alaska's health care system going?

Goals:

- What are your primary goals for improving health care cost and quality or transforming the health care system?
- What changes (if any) do you foresee to achieve these goals?
- Do you think an APCD could support you or your organization in achieving its goals?

Business Use:

- What are your most important uses health care data?
- What do you wish you could measure? Why can't this be measured now?
- What reports or information would you like to see out of additional measurement? Who is the audience?
- Do you think an APCD could help to fill in the gap for additional measures? Do you have ideas or thoughts on possible alternative data sources?

Data Atmosphere:

- What data do you currently use? Do you have specific likes/dislikes about it?
- What is your sense of the technical infrastructure in Alaska? How might an APCD affect this?

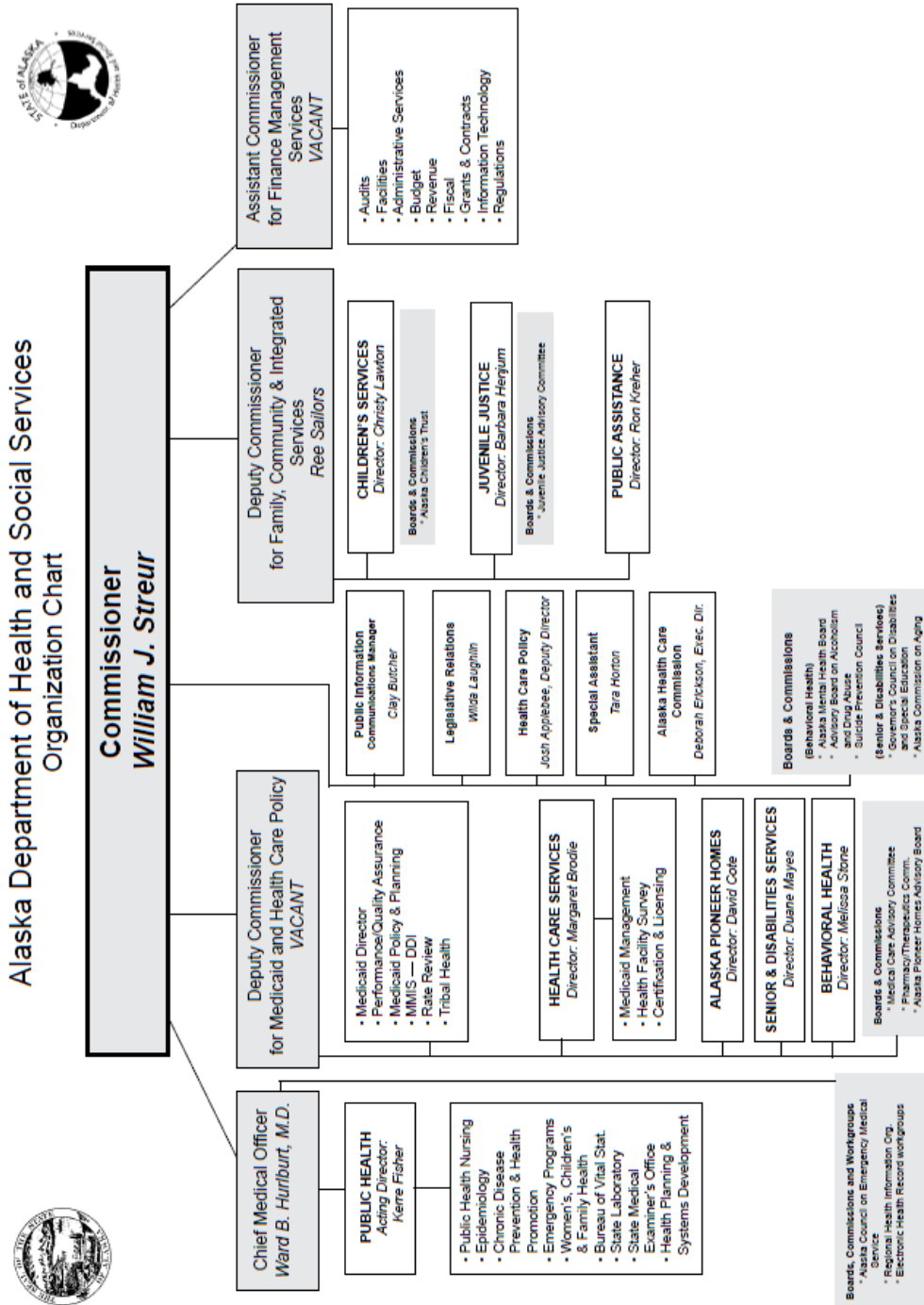
Organizational:

- How would a potential APCD be organized in Alaska? State agency, shared authority, etc.?
- Do you have thoughts on sources of support and/or sustainability for an APCD?

Concerns/Risks:

- What should be considered in designing this?
- What concerns do you have about implementing an APCD in Alaska?
- What are the risks to accomplishing the goal of an APCD in a high quality manner, or accomplishing it at all?
- How can those risks be best managed?

Appendix D: Alaska Department of Health and Human Services Organizational Chart



Appendix E: 2012 Health Care Commission Membership Roster

Alaska Health Care Commission Membership	
Name	Affiliation
Ward Hurlburt, MD, MPH	Chief Medical Officer, AK DHSS
Patrick Branco	CEO, Ketchikan General Hospital
C. Keith Campbell	AARP, former hospital administrator
Valerie Davidson	Senior Director of legal affairs, ANTHC
Jeffrey Davis	President, Premiera Blue Cross Blue Shield of Alaska
Emily Ennis	Executive Director, Fairbanks Resource Agency
Col. Thomas Harrell,, MD	Commander, Air Force/VA Joint Venture Hospital
Allen Hippler	CFO, Faulkner Walsh Constructors
David Morgan	Director of Reimbursement, Southcentral Foundation
Larry Stinson, MD	Clinical instructor (anesthesiology and pain medicine)
Robert Urata, MD	Medical Director, Wrangell Medical Center
Jim Puckett*	Director of Division of Retirements and Benefits, AK DoA
Representative Wes Keller*	Chair of AK House Health, Education, and Social Services Committee
Senator Donald Olson, MD, JD*	Senate Finance Committee representative

*denotes non-voting member

APPENDIX F: Background Information about Health Care in Alaska

A. Health Care Commission

In 2009, Governor Palin issued Administrative Order #246 establishing the HCC with the duty to serve as the state health planning and coordination body. In 2010, the HCC was authorized in statute to advise on policies to improve health and health care for all Alaskans. The HCC is located in the Department of Health and Social Services (DHSS) headed by Commissioner Bill Streur (see Appendix D for organizational chart). The HCC's 14 members include representatives from DHSS, hospital leadership, physician community, health insurance industry, military/VA sector, tribal health system, consumers, and legislators (Appendix E).

The HCC's vision is that "by 2025, Alaskans will be the healthiest people in the nation and have access to the highest quality, most affordable health care. The State will have achieved this vision when, compared to the other 49 states, Alaskans have the highest life expectancy, the highest percentage of access to primary care, and the lowest per capita spending trend." Measuring progress towards this vision requires deep and broad cost and quality data for decision-making.

B. Factors Unique to Alaska

Alaska is different from the lower 48 states in many dimensions, which may drive unique approaches to health care reporting and analysis. Alaska's relatively small population of 723,000 residents across a large geographic area of 571,000 square miles¹ affects choices of data sources and data reporting options.

Alaska has a diverse and comparatively young population. The state has a small Medicare population due to its young population, as well a high proportion of federal employees and military personnel². Two commercial payers dominate, with Premier Blue Cross having 70 percent of the total market share and Aetna 17 percent of market share³. Thirty four percent (34%) of the employer market is self-insured, with the State of Alaska being one of the largest purchasers, covering 6,400 current employees and 38,000 retirees. Figure 1 shows the payer distribution in Alaska.

This payer distribution has the following implications for potential APCD data collection:

- Claims data for the uninsured is typically not available. (16% of AK population)
- Indian Health Services organizations may be considering sharing health care data for individuals who received care through that agency; negotiations with the Oregon APCD are underway.

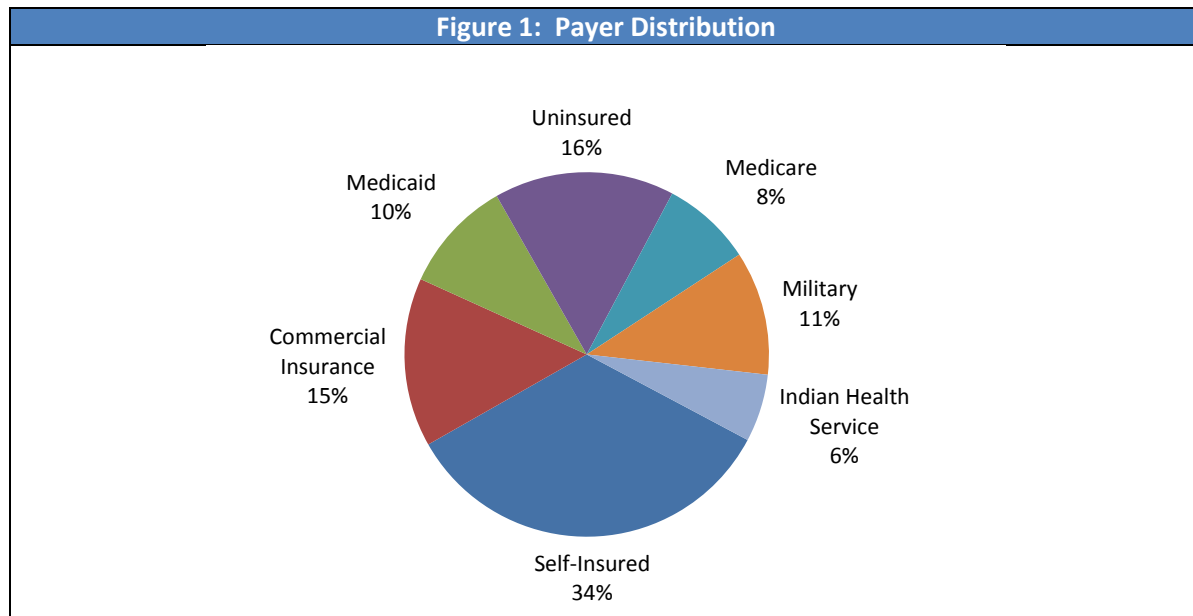
¹ U.S. Census Bureau: State and County QuickFacts, 2010. <http://quickfacts.census.gov/qfd/states/02000.html>

² The Trends 100, 25th Edition. <http://labor.alaska.gov/research/trends/jul11art1.pdf>

³ Insurers Writing Comprehensive Health Insurance in Alaska.

<http://commerce.state.ak.us/insurance/Insurance/programs/Consumers/Consumer%20Information%20page/Insurance%20Product%20Information/InsurersWritingComprehensiveHealthInsuranceInAlaska2010.pdf>

- Veteran’s Administration, TRICARE and federal employees groups have not yet shared data for their covered members with state APCDs (at least 11%).



Alaska Division of Insurance, 2010

There are 27 hospitals in Alaska, the majority of which are small rural hospitals. Alaska’s physicians practice solo or in small groups, with nearly 25 percent practicing within the ATHS. Alaska Natives have access to health care services through the ATHS, which includes 180 small community primary care centers, 25 sub-regional mid-level care centers, 4 multi-physician health centers and 6 regional hospitals. Some residents have additional sources of private or public insurance. For example, 30% of Medicaid enrollees are also American Indian/Alaska Natives, giving them access to health services available beyond ATHS.

Alaska has little experience with reporting requirements associated with managed care plans in other states. For example, California’s Office of the Patient Advocate and Utah’s Health Data Committee compile and report Healthcare Effectiveness Data and Information Set (HEDIS) data for commercial, Medicaid and SCHIP managed care plans. In contrast, just one PPO operating in Alaska reports data to NCQA.

C. Health Care Cost Drivers

Alaska is a relatively rich state with great mineral wealth and the second highest per capita Gross State Product.⁴ It is also one of the most expensive states to live in, and incomes are

⁴ Bureau of Economic Analysis, US Dept. of Commerce, 2011.

<http://www.bea.gov/iTable/drilldown.cfm?reqid=70&stepnum=11&AreaTypeKeyGdp=0&GeoFipsGdp=XX&ClassKeyGdp=NAICS&ComponentKe>

significantly higher than the lower 48 states (about \$61,000 in Alaska vs. \$50,000 nationally⁵). The high cost of living, transportation, labor and other associated costs is a challenge to establishing and maintaining a thriving business, including health care service delivery.

Health care spending in Alaska is increasing at unsustainable rates. Spending in 2010 reached \$7.5 billion, a 40% increase over 2005; at current trends, spending could double to more than \$14 billion by 2020⁶. Compared to the rest of the nation, Alaska's per capita health care costs are more than one third more than the national average (\$9,128 in Alaska compared to \$6,815 for the US as a whole.)⁷

In 2011, the HCC studied health care spending and cost drivers, identifying a range of factors that drive health care costs in Alaska. Cost shifting between commercial and public payers, high operational costs for health care providers and high physician reimbursement rates are some of the identified cost drivers that tend to amplify one another. Alaska is taking steps to understand where opportunities exist to quell the unsustainable cost of care. An APCD may provide the answer to this need to collect data for performance measurement and improvement efforts in the years to come.

[y=1000&IndustryKey=101&YearGdp=2011&YearGdpBegin=-1&YearGdpEnd=-1&UnitOfMeasureKeyGdp=Levels&RankKeyGdp=1&Drill=1&nRange=5](http://www.statehealthfacts.org/profileglance.jsp?rgn=3&rgn=1#y=1000&IndustryKey=101&YearGdp=2011&YearGdpBegin=-1&YearGdpEnd=-1&UnitOfMeasureKeyGdp=Levels&RankKeyGdp=1&Drill=1&nRange=5)

⁵ Kaiser State Health Facts, 2011. <http://www.statehealthfacts.org/profileglance.jsp?rgn=3>

⁶ Transforming Health Care in Alaska, 2011 Annual Report Highlights, Alaska Health Care Commission, with data provided by United Benefits Advisors.

⁷ Kaiser State Health Facts, Alaska. <http://www.statehealthfacts.org/profileglance.jsp?rgn=3&rgn=1#>

Appendix G: APCD and Transparency Initiatives in Other States

Arizona

- Revised Statutes §§ 36-125.04¹ and 36-436² (SB1142)
 - Signed into law by governor 04/18/2005
 - Requires the Arizona Dept. of Human Services to implement a uniform patient reporting system for all hospitals, outpatient surgical centers and emergency departments, including average charge per patient, average charge per physician
 - Requires the state to publish a semiannual comparative report of patient charges, and simplified average charges per confinement for the most common diagnoses and procedures
 - Arizona hospitals and nursing home facilities cost information can be found on the Department of Health Services, Division of Public Health Services
<http://www.azdhs.gov/plan/crr/cr/index.htm>

Arkansas

- Arkansas Code § 20-7-305³ (HB 1513)
 - Signed into law by governor 03/28/2007
 - Allows the Department of Health and Human Services to provide data for purposes of research to the Arkansas Center for Health Improvement, the Agency for Healthcare Research and Quality, or other researchers approved by the Division of Health and Human Services
 - Requires the Department to also provide data to Arkansas Hospital Association to use for its price transparency and consumer-driven health care project, that will make price and quality information about Arkansas hospitals available to the public
 - Arkansas Hospital Association consumer transparency website can be found at <
<http://www.hospitalconsumerassist.com>>

California

- SB 751⁴
 - Approved by governor September 2011
 - Revises existing § 10133.64 to prohibit a contract by or on behalf of a health insurer and hospital facility to provide inpatient services to subscribers and
 - The bill requires a health insurer to provide a hospital or facility with the opportunity to review the methodology and data used before cost or quality information is provided to subscribers or enrollees of the plan.
 - The bill would also establish requirements applicable to information displayed on an Internet Web site pursuant to these provisions by, or on behalf of, a plan or insurer.
- CA Health & Safety Code §1339.56⁵ (AB 1045)
 - Signed into law by governor 10/05/2005

¹ <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00125-04.htm&Title=36&DocType=ARS>

² <http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/36/00436.htm&Title=36&DocType=ARS>

³ <http://www.arkleg.state.ar.us/assembly/2007/R/Acts/Act616.pdf>

⁴ http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0751-0800/sb_751_bill_20110218_introduced.html

⁵ <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1339.50-1339.59>

- Requires that hospitals disclose prices for: the top 25 most common outpatient services or procedures and 25 most commonly performed inpatient procedures in California hospitals, as grouped by Medicare diagnostic-related group
- The office shall publish information on each hospital's average charges for these procedures on its Internet Web site(s)
 - <<http://www.oshpd.ca.gov/HID/DataFlow/index.html>>
 - <<http://www.oshpd.ca.gov/commonsurgery>>
- CA Health & Safety Code §1339.585⁶
 - Signed law in 2004
 - At the request of an uninsured individual, a hospital shall provide the person with a written estimate of the amount the hospital will require the person to pay for the health care services, procedures, and supplies. This estimate will include the cost of treatments and an average length of stay for a person with a similar diagnosis.

Colorado

- 25.2-1-204(10) CRS 2010⁷
 - Signed into law in 2010
 - Creates All Payer Claims Database (APCD) Advisory Committee to make recommendations regarding the creation of a CO APCD for the purpose of transparent public reporting of health care information
 - Specifies number and background of members, including researchers, physicians, employers, non-profit, consumers, insurers, etc.
 - Specifies types of reports and strategies that must result from the APCD, including value-based purchasing, comparative consumer information, alignment with other initiatives, etc.
 - Specifies CO APCD must be operational by 01/01/2013
 - Center for Improving Value in Health Care (CIVHC) is the non-profit organization as APCD Administrator, appointed in August 2010
 - CO APCD consumer website (based on historical data as of 01/02/2013) went live 11/01/2012 and is available here< <http://www.cohealthdata.org>>
- Colorado Hospital System to Post Out-of-Pocket Costs Online<<http://www.ihealthbeat.org/articles/2007/7/5/Colorado-Hospital-System-To-Post-OutofPocket-Costs-Online.aspx>>. Catholic Health Initiatives in Denver is collaborating with Centura Health to test hospital software that will allow patients to see what their out-of-pocket charges will be before they register to become patients. The system analyzes copayments, deductibles, coverage and the 10% to 20% of hospital costs that the patient is charged. The software estimates the cost for patients based on specific procedures and the patient's insurance.
- C.R.S. 6-20-101⁸
 - Signed into law in 2003
 - Requires hospitals and other licensed or certified health facilities to disclose the average facility charge for treatment that is a frequently performed inpatient procedure prior to admission for such procedure

⁶ <http://www.oshpd.ca.gov/HID/Products/Hospitals/Chrgmstr/PayersBillOfRights.pdf>

⁷ [http://www.leg.state.co.us/clics/clics2010a/csl.nsf/billcontainers/7772EFE1E998E627872576B700617FA4/\\$FILE/1330_enr.pdf](http://www.leg.state.co.us/clics/clics2010a/csl.nsf/billcontainers/7772EFE1E998E627872576B700617FA4/$FILE/1330_enr.pdf)

⁸ http://www.state.co.us/gov_dir/leg_dir/olls/sl2003a/sl_156.pdf

- HB 1278⁹
 - Signed into law 06/02/2006
 - Creates a comprehensive hospital information system to increase health care transparency
- HB 1385¹⁰
 - Signed into law 06/03/2008
 - Requires the Commissioner of Insurance to maintain a website that displays a consumer guide on insurance provided to the division by health insurance carriers; creates an exception for information that is proprietary pursuant to CO open laws; requires insurance producers, when soliciting or negotiating an application for coverage, to disclose financial information to consumers
- C.R.S.A. § 10-16-134¹¹
 - Effective 05/27/2008
 - On or before March 1, 2009, and on or before March 1 each year thereafter, each carrier shall submit to the division a list of the average reimbursement rates, either statewide or by geographic area, as defined by rule of the commissioner for the average inpatient day or the average reimbursement rate for the twenty-five most common inpatient procedures based upon the most commonly reported diagnostic-related groups. The commissioner shall post the information on the division's web site. The web site and information is easy to navigate, contains consumer-friendly language.
- C.R.S.A. § 25-3-705¹² (HB 1393)
 - Signed into law 06/20/2008
 - Requires the Insurance Commissioner with the Association of Hospitals to approve an information system that records charges for common inpatient procedures and diagnostic-related groups; requires the hospital charges to be available on an internet website; requires each health insurance carrier to report certain information, including reimbursement rates and includes that information on the website; requires the Health Care Task Force to study the submission of data by ambulatory surgical centers.

Connecticut

- Public Act No. 12-166¹³
 - Signed 2012
 - Establishes state's APCD
 - Specifies purpose for collecting, assessing and reporting health care information relating to safety, quality, cost effectiveness, access and efficiency for all levels of health care, subject to securing funds from the federal government and other private sources
 - Note: APCD is not yet operational

Delaware

- Del. Code Title 16, Ch. 20¹⁴

⁹ http://www.leg.state.co.us/clics/2006a/csl.nsf/fsbillcont3/23731D74537ED25C872570F8007A66D1?open&file=1278_ren.pdf

¹⁰ http://www.leg.state.co.us/clics/2008a/csl.nsf/fsbillcont3/400E4EC9B052A95087257402008275E0?open&file=1385_enr.pdf

¹¹ http://www.state.co.us/gov_dir/leg_dir/olls/sl2008a/sl_294.htm

¹² http://www.leg.state.co.us/clics/2008a/csl.nsf/fsbillcont3/A510DF3FEE240C41872573B400608165?open&file=1393_enr.pdf

¹³ <http://www.cga.ct.gov/2012/ACT/Pa/pdf/2012PA-00166-R00HB-05038-PA.pdf>

¹⁴ <http://delcode.delaware.gov/sessionlaws/ga135/chp143.shtml>

- Requires periodic compilation and dissemination of reports on charge levels, age-specific utilization patterns, morbidity patterns, patient origin and trends in health care charges.

Florida

- Florida has established a Web site that enables consumers to obtain data on hospitals' charges and readmission rates.
 - <<http://www.floridahealthfinder.gov/CompareCare/SelectChoice.aspx>>
- F.S.A. § 395.1051¹⁵
 - Signed into law 2004
 - A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request.
- HB 7073¹⁶
 - Signed into law 06/20/2006
 - Establishes the "Coordinated Health Care Information & Transparency Act," which provides better coordination of information for transparency purposes.
- Chapter 160 of 2012 requires clinics and medical offices to "publish and post a schedule of charges for the medical services offered to patients." http://laws.flrules.org/files/Ch_2012-160.pdf

Indiana

- IC 16-21-6¹⁷
 - The Indiana Hospital Financial Disclosures Law requires hospitals to provide the state with audited financial statements, Medicare Cost Reports, and gross charge information.

Iowa

- The Iowa Hospital Association has a Web site that provides information on every charge for any type of inpatient procedure in all Iowa hospitals.
 - Iowa Hospital Profiles is also the access point for aggregate discount information for private insurance, Medicare, and Medicaid, allowing users to compare charges to revenue for hospital services.
 - <http://ihaprofiles.org/>>
- HB 2539¹⁸
 - Signed into law by governor 05/13/2008
 - Institutes reporting requirements of annual compensation of certain officers and medical staff of non-profit health care providers to the state. A health care quality and cost transparency workgroup is created to recommend legislation to provide transparency to health care consumers.

¹⁵ http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=Ch0395/ch0395.htm

¹⁶ <http://www.myfloridahouse.gov/Sections/Documents/loadaddoc.aspx?FileName=h7073er.doc&DocumentType=Bill&BillNumber=7073&Session=2006>

¹⁷ <http://www.in.gov/legislative/ic/code/title16/ar21/ch6.pdf>

¹⁸ <http://coolice.legis.iowa.gov/Cool-ICE/default.asp?category=billinfo&service=billbook&GA=82&hbill=HF2539>

Kansas

- K.S.A 65-6801¹⁹
 - Signed January 2006
 - Creates state's APCD as a tool to review and compare utilization patterns, cost, quality, and quantity of health care services supplied in the state
 - Gives Kansas Health Policy group authority to specify rule and regulations of data release

Kentucky

- KRS 216.2929(1)²⁰
 - Requires that the Cabinet for Health and Family Services prepare and publish, in understandable language with sufficient explanation to allow consumers to draw meaningful comparisons, a report on health care charges, quality, and outcomes that includes diagnosis-specific or procedure-specific comparisons for each hospital and ambulatory facility.

Louisiana

- Louisiana has a voluntary reporting program called, "Louisiana Hospital Inform" <<http://www.lahealthinform.org/>> that is maintained by the Louisiana Hospital Association. The website provides pricing data on the most common Medicare inpatient and outpatient services, as well as quality data, demographic information and services offered at Louisiana hospitals.

Maine

- Title 22 §8703²¹
 - Signed 1995, revised 2003
 - Revised statute creates the Maine Health Data Organization and tasks it to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports
 - Specifies the database must be publically accessible while protecting patient confidentiality

Maryland

- Maryland Code Title 10.25, Chapter 6²²
 - Signed into law January 1996; revised October 1999
 - Creates the Medical Care Data Base, controlled by the Maryland Health Commission
 - Directs health insurers with total premiums over \$1M to submit all claims by December 31 of the prior year to the Maryland Health Commission
 - Specifies collected information includes: eligibility files, medical claims; pharmacy claims; provider directory; institutional services claims

¹⁹ http://kansasstatutes.lesterama.org/Chapter_65/Article_68/#65-6801

²⁰ <http://www.lrc.ky.gov/KRS/216-00/2929.PDF>

²¹ <http://www.mainelegislature.org/legis/statutes/22/title22sec8703.html>

²² <http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.25.06>

- First law of its kind in the country; precursor to other state APCD laws
- Reports can be found here
<http://mhcc.dhmfh.maryland.gov/healthinmaryland/Pages/healthcarereports/mcddb.aspx>
- The Maryland Health Care Commission provides consumers with an online hospital pricing guide that lists, for each acute care hospital in Maryland, the number of cases, the average charge per case, and the average charge per day for the 15 most common diagnoses.
 - http://mhcc.maryland.gov/consumerinfo/hospitalguide/hospital_guide/cost_report.html

Massachusetts

- As part of its health care reform law²³, MA established a website that allows consumers to compare the quality of hospitals and clinics, as well as the average payment for a range of services.
 - Massachusetts already had a website<http://www.mass.gov/healthcareqc>, but the new site will have much more information, including prices for hospitals and for the cost of prescriptions at individual pharmacies.
- Chapter 305, 2008²⁴
 - Establishes Division of Health Care Finance & Policy (DHCFP) to create the state's All Payer Claims Database
 - Specifies that de-identified information should be available to state agencies, researchers, and others for lowering total medical expense; coordinating care; benchmarking; quality analysis; administrative & planning purposes, and other tasks
 - Note: in 2012 law (see below) eliminates DHCFP and creates the Center for Health Information and Analysis (CHIA), which is tasked with operating the APCD
- Massachusetts recently passed SB2526,²⁵ making it the first state to set a goal limiting the future growth of health care costs.
 - The bill encourages the creation of Accountable Care Organizations that take a more coordinated approach to medicine, give residents better access to their records, and cut down on unnecessary testing. The bill's provision for ACOs is considered critical to the transition from a more piecemeal approach to medical care, in which doctors are paid for each test or procedure, toward a system focused on the best way to maintain a patient's overall health.
 - Establishes health care quality and cost council, which shall promote public transparency of the quality and cost of health care in the commonwealth, and establish health care quality improvement and cost containment goals. Specifies number and type of representation that must be met by collective members.
 - Requires the annual publication of Massachusetts Health Insurance Transparency Report for consumer and employer use. The report shall be compiled using data collected under this authority in the preceding year and shall include the average premium cost results by insurer, employer size category and by insurers' prototype or alternative prototype plan.

²³ <http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58>

²⁴ <http://www.malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter305>

²⁵ <http://www.mass.gov/legis/bills/senate/185/st02/st02526.htm>

- Requires a hearing if a health insurer files for an increase of more than 7% than the previous year's rates (for an identical category/coverage). All new rate filings shall be filled and advertised publically at least 90 days before the proposed effective date of such increase.

Michigan

- Michigan Hospital Association launched an online website in January 2008 with non-profit hospital prices for at least 50 medical tests, procedures and operations. See: <http://www.mihospitalinform.org/>

Minnesota

- MN 62U.04 Payment Reform; Health Care Costs; Quality Outcomes
 - Signed into law July 2009
 - Directs development of tools to improve costs and quality outcomes; calculation of health care costs and quality; provider peer grouping; encounter data; pricing data; contracting; consumer engagement.
 - Provider peer grouping involves: dissemination of data to providers; appeals process; innovation to reduce health care costs and improve quality
 - Result is MN's APCD, which is exclusively for use within the state's provider peer grouping project under this statute and unavailable to outside researchers.
- SF 3780²⁶
 - Signed into law 05/29/2008
 - Extends health care coverage to families with children earning up to 275% of the poverty line. The bill also gives patients more information on the cost and quality of care, offers incentives to providers to cut costs and improve quality.
- Minnesota's Web portal allows consumers to compare the average amount insurance plans pay to Minnesota health care providers for various medical procedures.
 - The portal lists the average amount health plans pay to 110 Minnesota health care providers for 103 common medical procedures.
 - It covers about 85% of primary care services in Minnesota.
 - The tool is an expansion of MN Community Measurement's existing site on quality measurements.
 - http://mnhealthscores.org/?p=cost_landing
- Some Minnesota health insurers unveiled or updated websites that allow their members to compare pricing and quality information for a variety of procedures and services.
 - Medica has a members-only comparison website listing the charges for common inpatient and outpatient procedures.
 - <http://www.medica.com/C18/NewsCostQualityToolbox/default.aspx>
 - HealthPartners maintains a members-only site that provides cost data for over 50 treatments and 100 services.
 - <http://www.healthpartners.com/portal/1900.html>
- The Minnesota Hospital Association <http://www.mnhospitals.org/> maintains a website called Minnesota Hospital Price Check <http://www.mnhospitalpricecheck.org/> that provides patients

²⁶ <http://www.health.state.mn.us/healthreform/legislation/sf3780.pdf>

with the cost of the 50 most common inpatient and the 25 most common outpatient procedures at specific hospitals.

Nebraska

- Rev. St. § 71-2075²⁷
 - Signed into law, 1984, 1995
 - Requires hospitals and ambulatory surgical centers to provide a written estimate of the average charges for health services.

Nevada

- NRS 439B.400²⁸
 - Requires all hospitals to maintain and use a uniform list of billed charges for units of service or goods provided to all inpatients. A hospital may not use a billed charge for an inpatient that is different from the billed charge used for another inpatient for the same service or goods provided.

New Hampshire

- Title XXXVII, Chapter 420-G, Section 11a²⁹ created the New Hampshire Comprehensive Health Information System (CHIS) with data used to provide information for consumers and employers on an interactive website called New Hampshire HealthCost (www.nhhealthcost.org). The site provides comparative information about the estimated amount that a hospital, surgery center, physician, or other health care professional receives for its services. For an insured individual, HealthCost provides information that is specific to that person's health benefits coverage. It also shows health costs for uninsured patients. Employers can use the Benefit Index Tool on the website to compare different carriers' health plan premiums versus benefit richness.
- New Hampshire has a hospital price website called "New Hampshire PricePoint" (<http://www.nhpricepoint.org>), which is sponsored and maintained by the New Hampshire Hospital Association. There is also a voluntary effort in Oregon called "Oregon Pricepoint" (<http://www.orpricepoint.org>), which is sponsored and maintained by the Oregon Association of Hospitals and Health Systems. These sites allow health care consumers to receive basic, facility-specific information about services and charges.

New Jersey

- New Jersey's 2008 law³⁰ caps hospital charges at no more than 15 percent above the Medicare payment rate for residents with a gross family income less than 500 percent of the federal poverty level. The law also requires that the state Department of Health and Human Services develop a sliding fee scale based on family income to be used in order to determine reasonable costs for hospital services.
- Two websites have been launched to help consumers make informed choices regarding price and quality of hospital services in New Jersey. The site <http://www.njhospitalpricecompare.com>

²⁷ <http://uniweb.legislature.ne.gov/laws/statutes.php?statute=s7120075000>

²⁸ <http://www.leg.state.nv.us/NRS/NRS-439B.html#NRS439BSec400>

²⁹ <http://www.gencourt.state.nh.us/RSA/html/XXXVII/420-G/420-G-11-a.htm>

³⁰ http://www.njleg.state.nj.us/2008/Bills/A3000/2609_11.PDF

includes a Top 25 DRG Search<<http://www.njhospitalpricecompare.com/topdrg.aspx>>; a separate site, <http://www.njhospitalcarecompare.com/> covers quality of care.

Rhode Island

- 23-17.17³¹
 - Signed 2008
 - Establishes state's APCD for the following purposes:
 - Determine capacity and distribution of existing resources
 - Identify health care needs and inform health care policy
 - Evaluate effectiveness of intervention programs on improving patient outcomes
 - Compare costs between various treatment settings and approaches
 - Provide information to consumers and purchasers of health care
 - Improve quality and affordability of patient health care and coverage
 - Strengthen primary care infrastructure
 - Strengthen chronic disease management
 - Encourage evidence-based practices in health care
 - Goals include additional access to consumer empowerment information for transparent, comparative cost and quality material
 - Statute prohibits state's collection of personal identifiers
 - Note: APCD is not yet operational

South Dakota

- SB 169³²
 - Signed into law by governor 03/01/2005
 - Requires hospitals to report the charges for the 25 most common inpatient diagnostic groups to the Department of Health, which must post the charges on its Web site.
- SDCL § 34-12E-8³³
 - Signed law 1994
 - All fees and charges for health care procedures shall be disclosed by a health care provider or facility upon request of a patient.
- SB 182³⁴
 - Signed into law by governor, 03/13/2008
 - Expands the state's existing hospital pricing Web site, which lists the median prices for the top 25 inpatient procedures at each of the state's hospitals, to include outpatient procedures.

³¹ <http://webserver.rilin.state.ri.us/Statutes/TITLE23/23-17.17/23-17.17-9.HTM>

³² <http://legis.state.sd.us/sessions/2005/bills/SB169enr.pdf>

³³ <http://legis.state.sd.us/statutes/DisplayStatute.aspx?Type=Statute&Statute=34-12E-8>

³⁴ <http://legis.state.sd.us/sessions/2008/Bills/SB182SHE.htm>

Tennessee

- Public Chapter 611 of the Acts of 2009³⁵
 - Established 2009
 - Creates the state's All Payer Claims Database and cites the following purposes:
 - Improving the accessibility, adequacy, and affordability of patient healthcare and healthcare coverage
 - Identifying health and healthcare needs and informing health and healthcare policy
 - Determining the capacity and distribution of existing healthcare resources
 - Evaluating the effectiveness of intervention programs on improving patient outcomes
 - Reviewing costs among various treatment settings, providers, and approaches
 - Providing publicly available information on healthcare providers' quality of care
 - Data will not be released to the public, and only analyzed at the population (not individual) level

Utah

- HB 9, Health Care Cost and Quality Data³⁶
 - Established 2007
 - Revises Health Data Authority Act to authorize Health Data Committee to collect data on costs of episodes of health care, and develop a plan to measure and compare costs of episodes of care
- The Utah Public Employee Health Plans (PEHP) published an online Treatment Cost Estimator Home and a separate PEHP Average Costs list for infant deliveries, effective 2008.

Vermont

- 18 V.S.A. § 9410
 - Signed 2009
 - Establishes the state's All Payer Claims Database as a resource for multiple stakeholders to measure performance of the state's health care system.
 - Specifies the APCD should: determine capacity and distribution of existing resources; identify health care needs and inform health care policy; evaluate effectiveness of intervention programs on improving patient outcomes; compare costs between various treatment settings and approaches; provide information to consumers and purchasers of health care; improve quality and affordability of patient health care and health care coverage

Virginia

- § 32.1-276.9:1³⁷
 - Signed April 2012

³⁵ <http://state.tn.us/sos/acts/106/pub/pc0611.pdf>

³⁶ <http://le.utah.gov/~2007/bills/hbillenr/hb0009.pdf>

³⁷ <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+32.1-276.9C1>

- Establishes state's APCD as a voluntary effort (in statute) between the Dept. of Health, Virginia Hospital and Healthcare Association, Virginia Association of Health Plans, and a nonprofit organization, Virginia Health Information
- Establishes state's APCD as a voluntary effort (in statute) between the Dept. of Health, Virginia Hospital and Healthcare Association, Virginia Association of Health Plans, and a nonprofit organization, Virginia Health Information
- Note not yet operational.

Wisconsin

- AB 907 (Act 228)³⁸
 - Signed into law, 2006
 - Dedicates state funds to the WI Health Information Organization (WHIO), a coalition of managed care companies, employer groups, health plans, physician associations, hospitals and doctors, to analyze and publicly report the health care claims information with respect to the cost, quality, and effectiveness of health care, in language that is understandable by laypersons. This law directs the state to collect credible and useful data for the purposes of quality improvement, health care provider performance comparisons, and consumer decision-making.
- In Wisconsin, information on hospital charges for common procedures is available online; basic price information is available on a website run by the Wisconsin Hospital Association<<http://www.wha.org/>> that draws on data collected by the state. Price Point<<http://www.wipricepoint.org/>>, displays typical charges and lengths of stay for individual hospitals, alongside state and county averages. Wisconsin lawmakers were among the first in the country to require hospitals to report their prices to the state. Consumer-facing reporting began 10 years later when the hospital association assumed responsibility for public reporting.

³⁸ <http://apps.leg.wa.gov/RCW/default.aspx?cite=70.41.250>

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